

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

RAPID ASSESSMENT OF ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMS, SERVICES AND POLICY ISSUES IN RWANDA



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I TABLE OF CONTENTS

- 1 TABLE OF CONTENTS.....3**
- 2 LIST OF ABBREVIATIONS4**
- 3 ACKNOWLEDGMENT.....6**
- 4 EXECUTIVE SUMMARY7**
- BACKGROUND.....11**
- 5 METHODOLOGY.....12**
 - 5.1 OVERVIEW OF ASSESSMENT.....12
 - 5.1.1 *Assessment versus Research*.....12
 - 5.1.2 *Pre-Assessment Review*.....12
 - 5.2 RAPID COUNTRY ASSESSMENT.....12
 - 5.3 SAMPLING FRAME13
 - 5.4 DATA COLLECTION14
 - 5.4.1 *Key Informant Interviews*.....15
 - 5.4.2 *Focus Group Discussions*15
 - 5.4.3 *Assumptions*.....15
 - 5.4.4 *Finalization and submission of Assessment Report*15
- 6 FINDINGS15**
 - 6.1 LEGAL AND POLICY ENVIRONMENT FOR ADOLESCENT HEALTH IN RWANDA16
 - 6.1.1 *Legal Framework*.....16
 - 6.1.2 *Policy environment*16
 - 6.1.3 *Coordination*.....17
 - 6.2 EXISTING PROGRAMS.....18
 - 6.2.1 *Government programs*19
 - 6.2.1.1 MINISTRY OF HEALTH19
 - 6.2.1.2 DEVELOPMENT PARTNERS19
 - 6.3 FINDINGS FROM YOUTH INTERVIEWS.....24**
 - 6.3.1 *Well being*24
 - 6.3.2 *Out-of-school youth issues*.....24
 - 6.3.3 *School, work and activities*25
 - 6.3.4 *Health and sexuality*25
 - 6.3.4.1 Unwanted pregnancy26
 - 6.3.4.2 Contraceptive methods.....27
 - 6.3.4.3 The sugar daddy/mummy phenomenon27
 - 6.3.4.4 Sources of RH information for the youth.....28
 - 6.3.5 *HIV/AIDS*.....30
 - 6.3.6 *Gender*30
 - 6.4 SERVICES AND HEALTH FACILITIES.....31
 - 6.5 KNOWLEDGE, PERCEPTION OF ADULTS/PARENTS ON RH32
- 7 CONCLUSION.....33**
- 8 RECOMMENDATION33**
 - 8.1 POLICY RECOMMENDATIONS33
 - 8.2 PROGRAM RECOMMENDATIONS.....34
- 9 REFERENCES.....35**

2 LIST OF ABBREVIATIONS

AERG	: Association des Etudiants et Elèves Rescapés du Génocide
AIDS	: Acquired Immune Deficiency Syndrome
ARBEF	: Association Rwandaise pour le Bien-Etre Familial's
ASRH	: Adolescent Sexual Reproductive Health
BCC	: Behavioral Change Communication
BSS	: Behavioral Surveillance Survey
CBO	: Community Based Organization
CHW	: Community Health Workers
CNJ	: Conseille National des Jeunes
CNLS	: National AIDS Control Commission
COPORWA	: Community of Potters of Rwanda
CSW	: Commercial Sex Workers
DANIDA	: Danish International Development Agency
DFID	: Department For International Development
FARG	: Fonds National pour l'Assistance aux Rescapés du Génocide
FAWE	: Forum for African Women Educationalists
FGDs	: Focus Group Discussion
FHI	: FHI
FP	: Family Planning
GIZ	: Deutsche Gesellschaft für Internationale Zusammenarbeit
GP	: General Paper
GS	: Group Scolaire
HC	: Health Center
HIV	: Human Immunodeficiency Virus
HMIS	: Health Management Information System
ICAP	: International Center for AIDS Care and Treatment Programs
IEC	: Information Education and Communication
IF	: Imbuto Foundation
IPPF	: International Planned Parenthood Federation
IUDs	: Intra Uterine Device
KII	: Key Informant Interviews
M2M	: Mothers-To-Mothers
MCH	: Mother Child Health
MIJEPFOP	: Ministry of Gender and Family Promotion
MINALOC	: Ministry of Local Government
MINECOFIN	: Ministry of Finance
MINICOM	: Ministry of Trade and Industry
MINIYOUYTH	: Ministry of Youth
MoE	: Ministry of Education
MoH	: Ministry of Health
NGO	: Non Governmental Organizations
NYC	: National Youth Council
ORINFOR	: Rwanda Bureau of Information and Broadcasting
OVC	: Orphans and Vulnerable Children
PAI	: Population Action International
PMTCT	: Prevention of Mother-to-Child Transmission of HIV
PSI	: Population Services International
PTA	: Parents Teachers Association

RAPP	: Rwandans Allied for Peace and Progress
RH	: Reproductive Health
RIEPA	: Rwanda Investment and Export Promotion Agency
RITA	: <i>Rwanda</i> Information Technology Authority
RNEC	: Rwanda National Electoral Commission
ROADS	: Regional Outreach Addressing AIDS through Development Strategies
SOS	:
STI	: Sexually Transmitted Illness
TB	: Tuberculosis
TRACPlus	: Center for Research on AIDS, Malaria, TB and other Epidemics
TWG	: Technical Working Group
UNESCO	: United Nations Educational, Scientific and Cultural Organization
UNFPA	: United Nations Population Fund
UNICEF	: United Nations Children's Fund
UPE	: Universal Primary Education
USA	: United States of America
USAID	: United States Assistance for International Development
WHO	: World Health Organization
YFC	: Youth Friendly Center
YPLWD	: Young People Living With Disabilities
YPLWHIV	: Young People Living With HIV
YRH	: Youth Reproductive Health

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The ASRH TWG members played a pivotal role providing technical assistance to guide the assessment about Adolescent Reproductive Health Programming. The findings of the assesment have been instrumental in the development of an ASRH national policy and strategic plan of action in Rwanda. In particular, the time and critical information provided by members of the ASRH TWG, representaives of organizations interviewed, district and health facility delegates, and all the youth groups allowed the authors the opportunity to successfully plan and implement the assesment.

This report draws on the previous experience on reproductive health research such as the one conducted by Dr Agnes Binagwaho, the Permament Secretary of MoH which proved to be highly informative. The report also reflects the substantial input from the policies and documents governing youth issues developed by different ministries forming the Social Cluster — namely: Ministry of Health (MINISANTE), Ministry of Infrastructure (MININFRA), Ministry of Education (MINEDUC), Ministry of Local Government (MINALOC), Ministry of Youth (MINIYOUTH) and Ministry of Sports and Culture (MINISPOC)

Finally, the authors would like to acknowledge the effort and commitment of the data collection team comprised of Mr. Idefonse NIYONSENGA, Ms GASAMAGERA Claire, Ms Chantal UMUHOZA, Mrs Diane SHUMBUSHO, Mr Emmanuel RUCYAHANA, Mr John Bosco KABANO and NDAGIJIMANA Lyhotely who were instrumental in the assesment data collection process.

4 EXECUTIVE SUMMARY

Introduction

The rationale to address adolescent reproductive health issues is supported by accumulating scientific evidence. For instance; two out of five unmarried females aged 15–24 were sexually active (Lancet, 2006). Eighty-two million girls in developing countries, aged 10 to 17, marry before their 18th birthday (UNFPA). As a result, every year, 14 million adolescent girls aged 15 to 19 give birth (Save the Children, May 2004), and are at risk of experiencing complications related to pregnancy and childbirth as the two leading causes of death among 15 to 19 year old girls worldwide (WHO, September 2008). There is a relative scarcity of data about reproductive health issues in Rwanda. Nonetheless, it is known that young people are sexually active. Findings from Rwanda BSS 2009 indicate that the median age at first intercourse is 16 and 17 years for males and females respectively. The same study indicated that 31% of youth aged 15–25 years reported ever having sex. Yet only 11% of Rwandan youths have comprehensive HIV knowledge (BSS 2009). Findings from another study indicated that 30% of Rwandan genocide survivors youth witnessed rape or sexual mutilation (International Journal of Epistemology, February 8, 2009) — all of which call the need for specific adolescent reproductive health programming. Accordingly the MoH has identified ASRH as a priority and; starting February commissioned a rapid assessment of such programs to inform development of an ASRH policy and strategic plan.

Objectives:

The goal was to analyze the current status of RH services and programs for adolescents/youth in Rwanda in order to provide a foundation for a policy and strategy document on comprehensive ASRH and rights. The following objectives were then adopted to achieve this goal.

1. To identify key stakeholders (policy, programming and research),
2. To analyze existing programs, research and services,
3. To identify youth RH and HIV/AIDS needs and resulting gaps, and
4. To recommend priorities for formulation of an ASRH policy and strategic plan including allocation of resources for health services, research and programming.

Methods:

The methods used included: 1) **A review of documents**, 2) **key informant interviews** with a wide range of stakeholders at national and district levels plus select out-of-school youth groups aged 20-24 years as well as 3) **focus group discussion** (FGDs) with in-school youth aged 10-19 years. Key informant interviews with out-of-school youth groups and FGDs with in-school adolescents took place in districts selected based on: whether they were urban or rural; existence of youth friendly center(s) or not in these districts. The districts were: Kicukiro, Bugesera, Rubavu, Muhanga and Gicumbi districts in Kigali City, Eastern, Western Southern and Northern Provinces respectively. In each of these districts a school and a health facility were purposively selected for FGDs with in-school youths and health facility assessment respectively.

A total of twenty-seven key informant interviews were conducted. Sixteen were conducted with governmental, UN agencies and non-government representatives at the national level while eleven were conducted across five districts with out-of-school youth groups aged 20-24 years, namely: Commercial Sex Workers (females), cooperative of women with low revenues (females) young people living with HIV (females), Youth Guides (Females), cyclists (Males), youth Scouts (males), youth members of tailors (females), traditional dancing association (Males), COOJAD members (Males), association of hand craft makers (females) and university Students (males and females).

In total, 16 Focus group discussions were conducted with in-school youth in five schools separated by sex and age; i.e. eight FGDs with 10-14 year olds (Boys & girls separately) and 8 FGDs with 15-19 year olds (Boys & girls separately).

Findings

Findings were grouped according to assessed areas which included: 1) Legal and Policy Environment, 2) Adolescent and Young adult wellbeing, 3) health and sexuality, 4) Reproductive health and HIV/AIDS, 5) Existing health programs and services as well as; 6) Parental and adult RH knowledge and attitudes.

Legal and Policy Environment

The assessment found that youth issues are addressed by many ministries directly or indirectly. Further, adolescent reproductive health is governed by many partially overlapping policies/strategies including; the National Reproductive Health Policy, the National Youth Policy, the Health Sector Policy, the Health Sector Strategic Plan 2009 — 2012, the Human Resources for Health Strategy; and the BCC Policy for the Health Sector. However a lack of legal provisions on certain RH issues such as the access to contraception and abortion for adolescents poses programming challenges. An attempt by the MoH to pass a legislation to legalize abortion was rejected while legalizing access to contraception by adolescents was blocked by law makers on grounds that it is against Rwanda cultural values.

Adolescent and Young adult wellbeing

All interviewed adolescents aged 10-19 years were in school. Key problems reported by adolescents in age category 10-14 years included; insufficient and unbalanced nutrition, strenuous work activities at home before or after school such as fetching water and firewood. These adolescents also reported isolated cases of school dropout as a result of lack of school essentials and in some cases children had to work for money to support their education

Most of the young adults interviewed in age group 20-24 years were not in school although the group was composed of university students. The majority had dropped out of school without completing. For this age group, life was reported to be a daily struggle to fulfil basic needs and/or responsibilities of food, shelter, clothing, healthcare, rent...etc. With limited employment options, majority of these young people largely work as casual labourers, street vendors (illegal in Rwanda). In certain extreme cases, a lack of skills to seek decent employment forced a few young adults to work as commercial sex workers.

Health and sexuality

Among adolescents and young adults aged 15-24 years, unwanted pregnancy and fear of being infected with HIV were the two major concerns. Most of these youths self reported being sexually active at an early age (youth estimated age of sex debut: 12 for girls; 15 for boys). They also reported non-use of condoms by some of their peers because of inability to access them due to barriers such as cost and other limitations especially for those in schools where condoms are not allowed. However, some youths were said not use condoms due to a number of other reasons. For example, it was reported that young people felt unprotected sex is more pleasurable; condoms smell bad and that girls think that condoms can get stuck in the vaginas. It was reported also that young people under the influence of alcohol might end up having unprotected sex. Lastly, it was reported that Rwandan girls do not actually openly consent to sexual intercourse.

As a result boys are unsure of the time lapse of wearing the condom that the girl will not change her mind and therefore end up having unprotected sex.

Some female adolescents who have unprotected sex end up becoming pregnant. This leads to many consequences including rejection by family; flight from family, school drop out, early marriage, premature parenthood, resorting to risky lifestyle including prostitution, and; unsafe abortion with a range of complication including death

The most important challenges reported across all youth groups include; inadequate knowledge on SRH and appropriate places to seek related information, limited access to contraceptives and condoms and non-use among youth, sexual violence among vulnerable groups and sexual manipulation of the young by older folks. In addition, cultural set up that hinders parents from talking to their children about sex was highlighted as a major limitation.

An emerging challenge facing female young people today reported among all youth groups particularly in secondary school was the sugar daddy phenomenon. Respondents at this level reported that this phenomenon affects girls more than boys. This was attributed to economic factors (students do it to gain money, some are given gifts), yet others do it due to peer influence (Contamination effect of sugar daddies) whereby students with sugar daddies convince their friends to indulge in the practice.

Some of the young people interviewed reported misinformation about contraceptives major among them being that they (contraceptives) are meant for adult married women and that contraceptives cause serious side effects such as infertility after termination. A perception limiting access to contraception is that young people will be interpreted as being sexually active by the community if they are seen requesting contraceptives.

Reproductive health and HIV/AIDS

Young people learn about reproductive health and HIV issues from different sources. These sources may be formal for those in school and non-formal both for those in schools and out of school. The non-formal sources include media, internet and from friends. Young people reported (in the same order of importance) peers relatives and friends, schools, media, health centres, youth friendly centres and Community Health Workers as being the most important RH and HIV/AIDS information sources.

Existing health programs and services

The assessment found that adolescent reproductive health programs and services were offered by a number of individual organizations highlighting a need for setting up a harmonized approach. Some of the identified programs include: School based RH education, Youth Friendly Centers, Peer education, ASRH/FP, Vocational Training for youth, IGA for youth, HIV/VCT, Mass media targeting young people.

In health facilities, RH services are provided to the general population in form of contraception and family planning. A lack of youth friendly characteristics (Provider Characteristics, Health facility characteristics and Program design characteristics) of these health facilities is a major obstacle to young people accessing the services.

Parental and adult RH knowledge and attitudes

Majority of interviewed parents reported that they do not talk to their children about reproductive health issues. Key reasons highlighted for not doing so is because they find it extremely difficult,

lack knowledge about the topic, they feel shy to talk about it (Rwandan culture discourages openly discussing sexual matters), they are too busy to talk about it, they believe that children get RH knowledge and skills from school, and that they feel that children do not want to talk about sex with their parents.

Policy Recommendations:

1. Develop an adolescent reproductive health policy that reflects and/or addresses specific adolescent needs as highlighted by the assessment;
2. Gather scientific evidence about the need for abortion care and contraception by adolescents to share with law makers;
3. Continue to advocate for the right to birth control methods, and post abortion care for young girls;
4. Work with the Ministry of Youth to develop a drug policy and strategies to rehabilitate youth on drugs;

Program Recommendations

1. Support youth friendly primary health care with more resources and staff training
2. Train medical staff and run awareness-raising campaigns on child and adolescent human rights;
3. Develop programs that encourage staff to desist from inappropriate and discriminatory behaviour towards adolescents
4. Strengthen programs for out-of-school adolescents to improve their life skills, through IGA and vocational training;
5. Address cultural barriers on youth sexuality and misconceptions through sensitization campaigns
6. Perform an analysis of health resource allocation, and ensure effective and efficient spending;
7. Help adolescents to assess their health needs and ask them for their view on health services;
8. Strengthen coordination efforts to allow creation of harmonized plans at different levels of government (supported by donors);
9. Work with the MoE to integrate RH within the education system (review curriculum, train teachers on RH)
10. Ensure increased availability of condoms and advocate for approval for use in upper secondary schools;
11. Create a strong monitoring system and use data for making management decisions
12. Engage communities to influence the environment outside school by involving community policing networks identify and report sugar daddy/mummies
13. Sensitize lodging/hotel and bar owners to put in place measures to deter sugar daddy/mummies
14. Invite all stakeholders to assist in all the efforts listed above

BACKGROUND¹

Although adolescents are seen as a healthy population who suffer from few life-threatening conditions, many of their behaviours, especially those related to sexual risk-taking, during this developmental phase can have life-long consequences according to the Association of Maternal and Child Health Programs.

Over the past 15 years, Rwanda has made significant progress in rebuilding its economic infrastructure, administrative that have been devastated during the genocide of Tutsis in 1994. The Rwandan health sector has grown and observed rapid increases in terms of indicators related to family planning (FP) and maternal and child health. The population that counts now for 11 million inhabitants and the fertility rates are among the highest in Africa, despite recent data showing a decline of fertility desire. Thirty-four percent of the Rwandan population is aged 10-24 years and almost 68% of the population is under 25 years. This demographic situation is causing a significant increase in basic social needs including education and health. The momentum built around a young population could undermine the country's resources for decades to come, despite the continued increase, whether recent or planned for the coming years, the use of contraceptives. On the other hand, the prevalence of HIV is currently 3% with a rate of 1% attributed to young people 15-24 years and more than 40,000 Rwandans receiving antiretroviral therapy, coverage rate of 72% persons seeking treatment. Still, like most sub-Saharan countries, Rwanda is facing a series of challenges preventing it from satisfying the health needs of its people, young and growing, in an economic context of the most delicate. The adolescent sexual reproductive health (ASRH) is an essential component of the policy Rwandan reproductive health adopted in 2003.

The ASRH component, looking at young people aged 10-24 years, included three general objectives:

- (1) Increasing knowledge about reproductive and sexual health among youth and adolescents
- (2) Encouraging adolescents to adopt a positive attitude in RH, in particular to reduce the incidence of STIs, the prevalence of HIV and unwanted pregnancy, and
- (3) The increased use of ASRH services in public and private health institutions.

The young range of population is also identified as vulnerable to HIV / AIDS. This vulnerability is higher among the teens whose physiological changes make them to be susceptible to contract infections. This situation in a matter of reproductive health explains the high exposure of adolescents to early pregnancies with the risk of abortions and obstetric complications. In addition, this target group is exposed to the use of alcohol, tobacco and psychotropic drugs that make negative impact on adolescents / youth health. Various studies conducted in this part of population have shown that adolescent and youth can not always access health services for economic reasons, social constraints and mainly due to lack of information on reproductive health. They are not always able to make good decisions about their health and health services are not able to provide hospitality and the needed care.

Against this background, Ministry of Health in collaboration with USAID/Rwanda, IntraHealth and IMBUTO Foundation conducted a quick analysis of the current situation of adolescents /youth reproductive health services in the country and assessment of the general knowledge of adolescents /youth about reproductive health and services with a view to inform formulation and development of a national policy and strategic plan for reproductive health of adolescents / young people in order to guide actions to support health needs of this target group.

¹ National Institute of Statistics, Ministry of Health, and Macro International, Rwanda Interim Demographic and Health Survey 2007-2008. Measure DHS, Macro International Inc., Calverton Maryland; and National AIDS Control Program, Rwanda, 2007.

5 METHODOLOGY

5.1 Overview of Assessment

5.1.1 Assessment versus Research

“Increasingly the gold standard for research in complex areas such as sexuality, gender relations and other social issues, is to begin with qualitative, exploratory data-gathering.”²

The proposed rapid assessment aimed to analyze the current status of reproductive health services and programs for adolescents/youth³ in Rwanda with a goal to provide a foundation for a policy and strategy document on comprehensive ASRH and rights. The tools and methodology were developed to ascertain collection of key information and provided an opportunity to:

- a) Identify key stakeholders (policy, programming and research),
- b) Analyze existing programs, research and services,
- c) Identify youth RH and HIV/AIDS needs and resulting gaps, and
- d) Recommend priorities for formulation of an ASRH policy and strategic plan including allocation of resources for health services, research and programming.

5.1.2 Pre-Assessment Review

The international consultant and National Consultant in close collaboration with the TWG conducted a technical review of the current ASRH situation in Rwanda to ascertain the framework that will assist in the rapid assessment, policy and strategic plan formulation and development. This initial information gathering was undertaken in-country over a two-week period in late November with an elaborate online and desk research done in December. Based on the results of the initial review, a team was set up to conduct a rapid assessment to provide information to enable MoH/Rwanda in developing an ASRH policy and strategic plan.

5.2 Rapid Country Assessment

Purpose: The goal was to conduct a country wide rapid assessment of the existing programs and services in ASRH in Rwanda; to identify areas of unmet needs especially with regard to at-risk-and-vulnerable populations; identify key stakeholders in the government, donor, non-governmental, and private sectors; and to complete a report of findings including policy, research, services and program recommendations for MoH.

The Assessment Team gathered information in-country through key informant interviews, health facility site visits, group discussions with youth and adults.

The data collection instruments were developed to respond to the following overall objectives:

- 1) Determining how youth RH/HIV/AIDS programs and health services address the needs of youth and in varying settings;
- 2) Examining the social and cultural contexts in which youth programming and service provision takes place;

² Pertti J. Pelto, Professor of Anthropology (Retired): *Qualitative and Quantitative Research Methods for Understanding Issues of Masculinities, Sexuality and Gender Equity*. November 2010, unpublished work.

³ For the assessment, we have adopted the definition of young people as segmented by WHO by age into three sub-groups: (a) Young adolescents 10 – 14; (b) Old adolescents 15 – 19; (c) Young adults 20 – 24.

- 3) Identifying technical and program gaps and challenges; and
- 4) Analyze and share stakeholder views on possible solutions to existing youth RH and HIV/AIDS problems.

5.3 Sampling Frame

Use of accurate, relevant information and participation of key stakeholders were essential for setting priorities for the proposed policy and strategic plans. The basic methodology proposed for the Assessment team to gather information in country was through a question and answer format. A combination of qualitative instruments were used to engage health practitioners, policy makers, development and health experts, adolescences 10 - 24 (peer educators, young cooperative members, YPLWHIV and YPLWD, district youth representatives), and adults (health facility professionals, parents and teachers, religious and community leaders) in the assessment⁴. The strategy was to use multiple information collection methods to enrich understanding and validate findings from a variety of sources.

Given that this was an assessment and not a scientific study, we **purposively** selected the assessment sites and participants.

Primary Target Population (10 - 24)

Using the WHO definitions, we held focus group discussions with segmented adolescents by age in three sub-groups: (a) Young adolescents 10 – 14; (b) Old adolescents 15 – 19; (c) Young adults 20 – 24. For groups (b) and (c), included married and unmarried, in-and-out of school youth. All groups included both male and female and were representative of the urban and rural adolescent populations.

Selection Criteria for Sites

The assessment was carried out in all 4 Provinces and Kigali City in order to provide an idea of the diversity as well as commonalities within the country. We selected one district within each province and selected one site within each district. Sites were further selected based on the presence of a Youth Friendly Centre (YFC).

Since we wanted to sample from both urban and rural settings, three sites in three districts were designated as a “rural” area of the district with the presences of YFCs. The other two sites in two districts to be approximated “urban,” were chosen by the absence of YFCs. Table below depicts the selection criteria for sites.

Table 1: A summary of criteria for selection of districts

	Kigali	Province 1	Province 2	Province 3	Province 4
	District 1	District 2	District 3	District 4	District 5
With YFC	Rural	Rural	Rural		
Without YFC				Urban	Urban

Assessment Team Composition and Requirements:

An Assessment Team was composed and consisted of:

- A national and international consultant (Architects of the Overall Assessment, Policy and Strategic Plan Phases and lead in key informant interviews)

⁴ Common key stakeholders for youth reproductive health include Program managers, Health policymakers, Professional associations, Advocacy groups, Male and female community groups, Private commercial suppliers, Religious groups, Donors, Male and female representatives of the general public, NGOs

- A quality and assessment team supervisor (To lead in the logistics and assessment process implementation, as well as the lead in field based assessment activities)
- Four youth consultants (Lead youth representatives in the assessment process as well as lead on the youth-focus group discussions)
- Three senior ASRH consultants from Rwanda (One senior ASRH and one Livelihoods expert to engage on the Youth-friendly services and district level stakeholders; and in collaboration with the supervisor, a BCC specialist to work with the youth consultants in conducting youth and adult focus group discussions).

NB: During the initial meeting, the team agreed on team assignments to ensure team members remained supportive of each other through out the assessment process. The team often divided to cover as many interviews as possible and also divided responsibilities for writing and preparation of the report.

The team worked in close consultation with the MoH and the ASRH TWG, holding regular briefings as needed.

The team met and interviewed a number of key stakeholders including community and youth groups as well as leaders and staff from youth-serving organizations and projects, United Nations agencies, donor agencies, government offices and the private sector.

Respondent characteristics

A total of twenty-seven key informant interviews were conducted. Sixteen were conducted with governmental, UN agencies and non-government representatives at the national level while eleven were conducted across five districts with out-of-school youth groups aged 20-24 years, namely: Commercial Sex Workers (females), cooperative of women with low revenues (females) young people living with HIV (females), Youth Guides (Females), cyclists (Males), youth Scouts (males), youth members of tailors (females), traditional dancing association (Males), COOJAD members (Males), association of hand craft makers (females) and university Students (males and females). In addition, a total, 16 Focus group discussions were conducted with in-school youth in five schools separated by sex and age; i.e. eight FGDs with 10-14 year olds (Boys & girls separately) and 8 FGDs with 15-19 year olds (Boys & girls separately).

5.4 Data Collection

Once the assessment team was recruited and data collection tools signed off by the ASRH TWG, data collection and ethical waivers obtained, data collection commenced immediately.

Health Facility Assessment:

The specific objective of the assessment of health facilities were:

- To thoroughly explore and gain a better understanding of how both health workers and youth define quality RH services,
- Assess the degree to which the RH services provided have these characteristics,
- Determine challenges and barriers to quality ASRH service provision, and
- Recommend steps that support necessary action to implement youth friendly ASRH services involving the health system, youth, parents and community leaders.

Target: In-depth Interview with Health Facility and Program Manager; and Focus Group Discussions with Health Centre Nurses, Counsellors and Community Health Workers.

5.4.1 Key Informant Interviews

Specific Objectives were:

- To identify the key stakeholders at institutional levels including Government, Non-Governmental Organizations, Civil Society Organizations and Donors work on Adolescent Health and Policy Issues,
- To review these stakeholders responses to adolescent's sexual and reproductive health programming and perspective on policy issues in Rwanda
- To identify gaps and challenges in addressing adolescent's sexual and reproductive health programming and rights
- To get recommendations on how to improve RH including HIV/AIDS prevention programming, services and policies for adolescents

Target: Local and International NGOs, and Umbrella Organizations; Representatives of Faith-Based Organizations at District level, Government Ministries and Agencies; and Donors Development and Agencies (Based out of Kigali); and CBOs and District Health Committees (at District Level).

5.4.2 Focus Group Discussions

The objective of the focus group discussions with the Adult groups were:

1. To identify barriers to parent-child communication on sexual reproductive health
2. To identify adult perceptions and understanding of youth reproductive health needs
3. To assess adults attitudes towards sexual reproductive health education and services

Adult Target: Adults from Parents-Teachers Associations at both primary and secondary school levels;

The objective of the focus group discussions with the representative groups of Young adolescents; Old adolescents and Young adults were:

1. To identify the services and programs offered to youth as perceived by young people
2. To assess the knowledge, attitudes and perceptions of young people with regard to RH/HIV prevention programs especially ASRH information and services
3. To assess the channels, barriers and challenges to accessing information and services including livelihood programs
4. To identify the key stakeholders in the community influencing adolescent reproductive health issues
5. To explore the perception of quality as defined by youth in the delivery of identified and existing ASRH services

5.4.3 Assumptions

The methodology was developed with the following limitations and assumptions:

1. There will be availability of funds
2. Informants and key stakeholders will be available in short notice
3. Both young people and adults in certain settings will be available

5.4.4 Finalization and submission of Assessment Report

The international, national consultants and assessment supervisor collaborated to incorporate changes to draft assessment report, and result framework. The finalized report and results framework will be submitted to TWG on February 18, 2011.

6 FINDINGS

The assessment results provide guidance on how the Technical Working Group on Adolescent Sexual Reproductive Health (TWG), under the leadership of the Ministry of Health (MOH)/Rwanda, can

specifically focus on the sexual reproductive health needs of youth ages 10-24 within the broader context of its country policy and strategy. The findings and recommendations from the assessment also serve as input to the development of the policy and strategic plan, as well as to suggest adjustments to the current set of activities supported by the various stakeholders, in particular, Ministry of Health, Ministry of Youth, Ministry of Education, CNLS, TRAC, Health Development Partners, Umbrella Organizations of Civil Society and Local NGOs/CBO's (such as CBO's of PLWHIV, PLWDisabilities etc) and Faith-Based Organizations. The findings also serve the needs of the broader group of stakeholders interested in improving the SRH and HIV/AIDS situation of young people in Rwanda.

6.1 Legal and Policy Environment for Adolescent Health in Rwanda

6.1.1 Legal Framework

A lack of legal provisions on certain RH issues (contraception and abortion for adolescents adds to the challenge of program design and implementation)

It was observed during the assessment, that RH programs are run and services provided as part of a continuum of health services (this will be described further under section 5.4 of this report) without specific consideration for ASRH. That ASRH is not given a specific consideration in the exiting policy and legal frameworks provides an opportunity for program and service provision improvements in terms of increased focus on ARH within the health system mainstream. In addition, there still exist legal obstacles with regards to this. For example, the MoH has been advocating passage of two related legislations; namely on the right to abortion and to contraception by adolescents. Both have not been passed by the parliament. The former was rejected while the latter was blocked by parliamentarians who argued that they are against Rwandan values.

The MoH recognises the importance of these laws as cornerstones for successful policy and strategic plan implementation. As such, MoH will continue to advocate, raise public awareness and gather information to accumulate scientific evidence to demonstrate the need of these legislations to parliamentarians.

6.1.2 Policy environment

Adolescent health is governed by many partially overlapping policies/strategies, and several ministries are directly or indirectly concerned

The government of Rwanda places great emphasis on addressing youth issues. Adolescent health is governed by many partially overlapping policies and several ministries of which the following are directly or indirectly concerned with those issues⁵

1. Ministry of Health,
2. Ministry of Youth,
3. Ministry of Gender and Family Promotion,
4. Ministry of Education,
5. Ministry of Local Government,
6. Ministry of Sports and Culture

Many of these institutions have developed policies to address certain health aspects of the youth. While the National Reproductive Health Policy and the National Youth Policy may be the most important, a number of other policies and strategies addressing youth needs do exist as well. These include: the Health Sector Policy, the Health Sector Strategic Plan 2009—2012, the Human Resources for Health Strategy, Behavioural Change Communication Policy for the Health Sector, Community Performance Based Financing Guide, and the National Community Health Policy.

⁵ Report on adolescents' health and HIV services in Rwanda, in the context of their human rights, Dr Agnes Binagwaho; 2009

Both (the youth and National Reproductive Health Policy) cover adolescent health partially but they fail to address the key issues of adolescent health in a comprehensive way⁶. The remaining policies do not necessarily address adolescent health issues or do so just inadequately.

The Ministry of Health guidelines that define the standards (Standard Procedures in Family Planning, Infertility, Youth Consultation, and Gender-Based Violence) of care to the adolescents does not clearly address adolescent needs. The standard IEC procedures (information, education, communication) on family planning define services and care related to gender-based violence for adolescents. However, these are defined in more general terms without explicit guidance to decentralized (district and facility) level health management cadres.

6.1.3 Coordination

Youth programs and services are provided but their need for a more harmonized approach

There have been coordination efforts between ministries concerned with RH issues. The National Reproductive Policy⁷ identifies three major weaknesses as;

- Insufficient information on the implementation interventions, resulting in redundant efforts and squandered resources;
- Lack of follow-up of accomplishments and of evaluation of results achieved;
- Weaknesses in understanding the responsibilities of each intervening party.

It also mandates the MoH as the coordinating body and lists other institutions with their respective RH intervention areas as shown in the table below:

Table 2: RH services/programs implemented by different ministries

RH Components	Responsible
Safe Motherhood and infant health	MINISANTE, MINALOC and MINEDUC
Family Planning	MINISANTE, MINEDUC, MINALOC and MIJESPOC
Prevention and treatment of Genital infections, STIs/HIV/AIDS	MINISANTE (TRACPlus), MINEDUC, MINALOC, MIJESPOC, MINADEF and CNLS
Adolescent reproductive health	MINISANTE, MINEDUC, MINALOC and MIJESPOC
Prevention and Management of Sexual Violence	MINISANTE, MINEDUC, MINALOC, MIJESPOC, MINIJUST and MIGEPROF
Social changes to increase women's decision power	MIGEPROF, MINEDUC, MINALOC and MINISANTE

The policy further recommends two coordination units: one addressing health issues under the MoH and another under MINALOC to coordinate all IEC/behavior change communication (BCC) interventions. For aspects specific to their mandates, coordination efforts for other institutions were left to their discretion. For instance, MIJESPOC has an IEC section focused on adolescents, and MIGEPROF has a section responsible for control of sexual violence (in close collaboration with MINIJUST, MINALOC and MINADEF). The National AIDS Control Commission ensures the coordination of HIV/AIDS prevention interventions.

⁶ Report on adolescents' health and HIV services in Rwanda, in the context of their human rights, Dr Agnes Binagwaho; 2009

⁷ National Reproductive Health Policy; 2003

The, assessment found that RH issues are currently addressed under the Social Cluster — a forum that brings together six ministers on a quarterly and their Permanent Secretaries on a monthly basis. The nascent ASRH TWG is one of the groups under the social cluster providing it with technical information for decision making.

Further coordination efforts should build on this existing structure. Strengthening the ASRH TWG to actively engage partners involved in RH, harnessing joint planning, implementation and monitoring of RH related programs will be critical.

6.2 Existing programs

There are currently a number of reproductive health programs and services being offered in Rwanda—mainly run by government agencies plus international development partners and NGOs.

Therefore, in addition to health facility visits and youth interviews, the assessment also met with personnel from the MOH and MINICYOUTH, as well as their key partners— to learn about youth reproductive health initiatives they currently support. A summary of the service delivery programs offered to youth by different institutions is provided in the table below, categorized by the type of services provided.

More information about the services provided by each organization listed, as well as information about other organizations visited, will be found in Annexes of the final report. However, a brief summary of the types of existing programs and policy initiatives that support youth reproductive health, as well as the donors that fund them, follows.

Table 3: Types of Youth Reproductive Health Service Delivery Programs Observed

Service Organ.	Sch. based RH Edn	General Clinic	GBV	MI	Youth - Friendly Clinics	Peer Ed.	ASRH/FP	Vocational Training	IGA	Mass Media	HIV/ VCT	12+ program	Care & Support/ OVC	RH policy & strategy
MoH		✓												
MoE	✓							✓						
UNFPA					✓		✓							
UNCEF														
GIZ			✓	✓			✓							
IF						✓	✓		✓	✓	✓		✓	
RAPP							✓			✓	✓			
PSI					✓					✓		✓		
ARBEF			✓				✓				✓			
FHI											✓			
ICAP											✓			
CARE													✓	
RLCS							✓				✓			
World Vision							✓				✓			
CHF													✓	
WHO							✓				✓			✓

6.2.1 Government programs

Despite legal and policy issues described previously, Government support for youth reproductive health (YRH) is strong. For Government authorities, major concerns related to RH include prevention of unintended pregnancies, STIs, and HIV among youth. The Permanent Secretary of the Ministry of Health is an ardent advocate youth RH not only as a service but also as a right.

The principal government ministries and offices that provide youth programs and services include the Ministry of Health, the Ministry of Youth, Sports, and Culture, the National AIDS Control Commission (CNLS), and the Ministry of Education. The assessment team particularly focused on the Ministry of Health; a brief summary of this institution follows.

6.2.1.1 MINISTRY OF HEALTH

Reproductive Health is a critical area for the MoH according to the Health Sector Strategic 2009–2012. However, only 10 health centres out of 406 in the country offered youth friendly reproductive health services (HMIS, 2008). In addition, the plan proposed accelerating integration of FP/RH services in HIV prevention services for adolescents at the youth centres in addition to defining of a minimum package for Adolescent reproductive health services among others.

The MoH provides overall stewardship of health issues (including RH), even though this cuts across various ministries. The sector is also supported by development partners, faith-based organizations (FBOs), and non-governmental organizations (NGOs).

At the national level, adolescent health activities are implemented by the Maternal and Child Health Taskforce (MCH) and the desks for STIs. Other task forces under the same ministry (Mental Health and Community Health) have overlapping responsibilities with regards to adolescent health. How these overlaps must be coordinated has not been clarified.

Through health facilities, RH services are provided as part of the minimum health service package defined by the MoH. In Faith Based facilities, health posts are established nearby. In these health posts, potential service beneficiaries from the catchment area of the “*mother health center*” are provided with RH/FP services by staff from the same health center.

6.2.1.2 DEVELOPMENT PARTNERS

- ***Population Services International (PSI)***

Population Services International (PSI) focuses on social marketing of HIV prevention, family planning and maternal and child health. PSI works in partnership with the public and private sectors to provide, sexual reproductive health services and behaviour change communications (BCC) with the aim of empowering the world's most vulnerable populations to lead healthier lives. PSI/Rwanda engages in three main program areas: product-related social marketing, targeted service delivery, and targeted evidence-based BCC using mass media and intensive community outreach through RPOs (Rwandan Partner Organizations) in order to address barriers to improving family health.

PSI targets both in school and out of school youth within the age group 15-24 and dedicates 50% of its funding to youth programs. These include; HIV prevention among youth through its youth friendly centers, social marketing of products to control diseases like Malaria (Tuzanet), promotion of condoms, hygiene and sanitation (Sur eau). In addition PSI/Rwanda is currently implementing an innovative, evidence-based program known as ‘12+’, under the leadership of the Ministry of Health (MOH), and in partnership with Nike Foundation, Girl Hub, and the Association des Guides du Rwanda (AGR). This 2011 pilot project is designed to

reach 600 adolescent girls between the ages of 10–12 years, a critical period in their lives, with information and tools essential to ensure their healthy and promising future. The program will be implemented in four districts: Kicukiro, Huye, Musanze and Ngoma and will involve three schools, a youth center and a health center per district. With guidance from locally-selected, trained, female mentors (aged 18-25) and 12+ program staff, and with permission from their parents/caregivers, the girls will follow a series of creative, MOH-approved, age-appropriate, extra-curricular training modules on topics including financial literacy, fundamentals of puberty, adolescent pregnancy and its consequences, HIV and other STIs, and negotiation and rights and responsibilities. The girls will also embark on supervised, fun "adventures" such field trips to a nearby health center and a bank. Along the way, the girls record their participation in 12+ "passports" (to measure their exposure to different program elements) as well as personal journals. Lessons learned from the 12+ pilot will inform its scale up both nationally and internationally, starting in 2012. The pilot project will reach 600 girls (150 per district) and 48 mentors (12 per district).

- ***Rwandans Allied for Peace and Progress (RAPP)***

RAPP is a no governmental organization that promotes public sexual and reproductive health. RAPP is mainly funded by a Germany organization called ACTION MEDEOR. RAPP implements different programs and projects in 13 sectors in different districts but does not have any specific youth program. For example in one of their projects called *amajwi y'ubuzima*, they do open theatre performances with messages on family planning, HIV/AIDS and they target the general population.

- ***Imbuto Foundation***

Imbuto Foundation is a Rwandan non-profit-making organization in accordance with law N°20/2000 of July 26th, 2000. The vision of Imbuto Foundation is *a nation of empowered and dignified Rwandans* and its mission is *to support the development of a healthy, educated and prosperous society*.

Imbuto Foundation's work is aligned to national priorities and fulfils its mission through advocacy, community outreach, mentorship, fostering partnerships and unleashing young talent. Imbuto foundation invests in Health and Socio-Economic Development portfolios through following projects:

- **Health projects :**

- Family package ;
- Mothers 2 Mothers ;
- Reproductive Health ;
- Malayika Mulinzi Campaign ;
- Malaria Campaign

- **Socio-Economic Development Projects:**

- Scholarship;
- Promotion of girl's education campaign ;
- Youth forum series and workshops;
- Celebrating young Rwandan achievers;
- Enhancing public speaking among youth
- Income generating activities

- **IntraHealth International:**

IntraHealth is supporting the government and policy-makers to further develop and promote a comprehensive, evidence-based national reproductive health program that respects the rights of

individuals. This effort, along with assistance to further expand family planning services to include emergency contraception and post abortion care, is being carried out thanks to a grant from the William and Flora Hewlett Foundation. IntraHealth documented the process and outcomes of integrating family planning into its HIV/AIDS programs in Rwanda through an USAID found and a grant from the Tides Foundation. This work will help ensure that clients entering Rwanda's health care system for HIV services also receive the family planning and reproductive health services they need. With a grant from the David and Lucile Packard Foundation, IntraHealth is developing and test a model of gender-appropriate, youth-friendly services and build support for such services among health, education, and civic professionals and officials.

Current Projects:

- HIV/AIDS Clinical Services Program (funded by USAID, led by IntraHealth, 2007 -2012)
- Expanding Rwanda's Commitment to Population, Family Planning and Reproductive Health (funded by the William and Flora Hewlett Foundation, led by IntraHealth, 2008 - 2011)
- Rwanda Adolescent Reproductive Health Initiative (funded by the David and Lucile Packard Foundation, led by IntraHealth, pilot project, 2009 - 2011)

Past Projects:

- INTRAH worked in Rwanda as a program of the University of North Carolina during the years 1987 to 1993 and resumed its activities in 2000 until today.
- PRIME II Project (funded by USAID, led by IntraHealth, 2000 - 2004)
- Capacity Project (funded by USAID, led by IntraHealth, 2005 - 2009)
- Enhancing Client Access: Integrating Family Planning and HIV/AIDS Services in Rwanda (funded by the Tides Foundation, led by IntraHealth, 2007 - 2010)
- HIV/Performance-Based Financing Project (funded by USAID, supporting partner, 2005 - 2009)
- Twubakane Decentralization and Health Program (funded by USAID, led by IntraHealth, 2005 - 2009)
- ***Association Rwandaise pour le Bien-Etre Familiales (ARBEF)***

ARBEF is the Rwandese association for family welfare; it is a non governmental organization that was founded in 1986. Its focus is on sexual and reproductive health and rights of the general public. ARBEF's Programs are Sexual and Reproductive Health based, for example adolescents sexual and reproductive health, increasing access to reproductive health services, fighting against HIV/AIDS and Advocacy for unmet reproductive health needs like safe abortion.

ARBEF's main sources of funding are: IPPF, USAID, DANIDA, ICAP, CONCERN, UNFPA, PAI, Rutgers Nisso Groep (Youth Incentives Funds) and approximately 70.000.000 Frw per year is allocated to youth programs.

ARBEF is currently implementing a project funded by DANIDA that Fights sexual taboos in nine-year basic education in Huye, Nyanza and Gisagara district in the southern province.

ARBEF targets all age groups, both in and out-f-school young people and both male and female populations. It has a youth branch where young people 25 years and below participate in planning, decision making and implementation of various programs and projects.

- ***International Center for AIDS Care and Treatment Programs (ICAP)***

The International center for HIV/AIDS treatment programs, Columbia University (ICAP) is government of Rwanda clinical partner working at the central district and health center level. Support government to provide a whole continuum of HIV Clinical services. ICAP gives policy guidance, contributes to the development of treatment protocols and guidelines, HIV/AIDS treatment and development of referral

systems and capacity building for Health centers. ICAP also have FP, Tuberculosis and mental health programs.

The focus is HIV services for all age groups but PMTCT program addresses in different ways RH issues like the prevention of risky pregnancies in discordant couples

ICAP targets all age groups requiring HIV related services and youth is not ICAP's primary focus even if there are many youths in the ICAP's paediatric component.

- ***Réseau Religieuse de Lutte Contre le SIDA (RLCS)***

RCLS started in 2007, with the Purpose, vision, and mission of coordinating religious organizations against HIV/AIDS, Harmonizing HIV/AIDS messages with biblical and Quran health understanding. The organization offers programs like Capacity building through Training on HIV AIDS and maternal health, fighting malaria and Tuberculosis, Reproductive health, HIV-AIDS, community health and Family Planning among others.

RCLS has RH and HIV prevention services for youth which are accessed through support groups and are linked to health centers. Mentorship being one of the preventive services is done through 'Mama est toir'.

The organization deals with livelihood component like weaving, agriculture, livestock, lumbering. It also, focuses on vocational training. The national policies have addressed livelihood related issues of vulnerable groups and improving the jobs, access to finance through Girinka Munyarwanda, Ubudehe, Girls promotion campaign (Fata Umwana wese K'uwawe) and legal aid.

RNLS has various partners and notable of them include, Global fund, world vision, CNLS, UNFPA, UNICEF, Christian AID, MINICOFIN, MOH, UNESCO. About 80 million per year is reserved for youth year. The organization target religious leaders at national level and then at congregation level through faith based organization of youth, women and religious leaders living with HIV/AIDS.

- ***World Vision***

The purpose of the organization is to promote life skills among its targeted beneficiaries through IDP projects which include education, Health, Agriculture, Peace Building, OVC project and these programs include RH and HIV/AIDS.

World vision Rwanda gets its funding from world vision Australia, Canada, USA, New Zealand and Taiwan and 50% is for IDP which is normally for youth.

World vision collaborates with government ministries and agencies notable of this include, MCH, MOH, MINIDUC, MIGEPROF, MINICYOUTH, and this is done through signing a memorandum of understanding that clearly stipulates the working dynamics.

World vision's primary audience is youth in and out of school. Its secondary audiences are parents and Faith based organization. The reason is that world vision wants to empower the children between 10-24 years.

World vision offers livelihoods to youth, notable, vocational training, youth cooperatives, and training in life skills development.

- ***CARE International***

CARE International is an international organization that seeks a world of hope, tolerance and social justice. It aims at strengthening capacity for self help, providing economic opportunity, delivering relief in emergencies, influencing Policy decision at all levels, Addressing discriminations in all its forms. The main programs that are being implemented include *vulnerable* women, program for people historically marginalized and OVC program.

CARE's programs include RH and HIV services like family planning, HIV/AIDS, OVC support psycho-social issues.

CARE targets both in school and out of school youth between 0 – 18 years, especially young girls, and children less than 6 years.

- ***Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and the German Development Cooperation***

Established on 1 January 2011, GIZ brings together under one roof the long-standing expertise of the Deutscher Entwicklungsdienst (DED) gGmbH (German Development Service), the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German Technical Cooperation) and InWEnt – Capacity Building International, Germany. As a federally owned enterprise, GIZ supports the German Government in achieving its objectives in the field of international cooperation for sustainable development. Since launching operations in Rwanda in 1979, German bilateral cooperation concentrated on strengthening the following sectors:

- Health
- Sustainable Economic Development
- Good Governance

In all three programmes, adolescents are one of the target groups. The Health programme supports the Ministry of Health, the District Health Units as well as the health facilities in five target districts in improving sexual and reproductive health for adolescents aged 10-24 including preventing and addressing the various forms of GBV. The ASRH programme is rounded-up by peer education activities at decentralized level. Furthermore, the PSI Abajene program is financially supported by the Kreditanstalt für Wiederaufbau (KfW).

The programme for Sustainable Economic Development focuses on Technical and Vocational Training (TVET). Youth is one of the main target groups for the Civil Peace Service (ZFD) to enhance the reconciliation process in Rwanda. With the support ZFD youth organizations of the Rwandan civil society implement different tools of conflict resolution especially in trans-border regions. The long term partner of GIZ and CPS *Forum des Jeunes Giramahoro* for example carries out the conflict sensitive youth radio show HEZA .

- ***Family Health International (FHI)***

FHI/RWANDA started in 1993 to contribute in the health sector in areas like fighting against HIV/AIDS, STIs and family planning. In 2008 FHI conducted a research about the non-use of FP modern methods in Rwanda.

FHI mainly provides support to implementers in the health sector like district hospitals, health center and other community organizations. It gets its funding from European Union, USAID, and donors from American families.

FHI collaborates with other organizations in offering providers, creating programs. The partners in social psychology are Ruhuka. In economic terms there are COPORWA, Rwanda Women Network, CHF, CRS, Right-To-Play; Search for Common Ground, World Vision, MIGEPROF, MINEDUC, MOH, MINALOC and School of Public Health.

FHI has a youth-focused component: the TIP prevention intervention that targets youth among other at risk population; the children psychosocial service that helps announce HIV-diagnosis and the support to OVCs for school and life-skills (through ROADS) and about 60% of its funding is devoted to youth focused interventions.

6.3 Findings from youth interviews

The vast majority of youth aged 10-19 is in school, however drop out and child labour was reported

6.3.1 Well being

School going youth reported life challenges related to their well being almost in all FGDs. Kigali groups reported less of such problems. For instance, insufficient and unbalanced diet mainly composed of potatoes or cassava flour, yellow posho, lack of clothing, issues related to lack of money to buy school essentials were the problems captured by the assessment across 10-14 year focus groups. Despite UPE these youth also reported cases of school drop out attributed to poverty since many of the parents were unemployed or a delay of salary for working parents.

Many of these cut across youth groups in districts assessed. However some issues were reported only in certain districts. For example; in Bugesera district, it was reported that some youth work on the farm, as street vendors or as day labourers on construction sites. In Muhanga and Bugesera districts, six out of ten girl and boy youth in age groups 10-14 interviewed reported that they fetch water in the valley before and after school.

“Many of us fetch water carrying 20 litre Jerri cans before or after school in the morning or in the evening” (FGDs, GS Shyogwe, Mareba)

In Rubavu district some youth reported that they carry luggage for passengers, wash cars and do other job — sometimes to raise money for school. In one particular case, a youth respondent reported that he repeated Primary five because he had to raise money for school by fabricating and selling stoves (*Imbabura*).

“I repeated form 5 because I used to fabricate stoves (Imbabura) to earn money for school fees” (FGD GS Gacuba II)

On the other hand, youths of the same age in Kigali generally reported better well being situations as compared to their counterparts in the rural or semi urban settings. In this regard, ten out of ten youth interviewed reported getting three meals a day, and three out of ten said eat meat at least every week. Only two out of ten reported having no health insurance while the majority of their counterparts in the rural or semi-urban settings did not have health insurance at the time of assessment.

Although each member of the FGD in this age category reported knowing someone of the same age group in their local communities who did not attend school, it was generally believed that these cases had reduced considerably as a result of Universal Primary Education. Key reasons for these children not attending schools were said to be due to lack of school essentials (other than school fees) such as PTA, failure of parents to raise money to construct extra class rooms for UPE and parental ignorance.

Although no respondent attested to using drugs, the problem was captured across all FGDs and is said to a major challenge faced by youth, especially those out of school. Some of the drugs mentioned are marijuana and some locally brewed alcoholic drinks (Cheap Warangi, Mugo faurahs, Ihogoza among others).

6.3.2 Out-of-school youth issues

Youth interviewed (especially those out-of-school struggles to fulfil their basic needs and or responsibilities.

Whereas it is true that out-of-school youth were faced to some extent with similar challenges as described above (except those related to schooling), these youth reported peculiar challenges. The findings reported below were captured across groups drawn from cooperatives and/or associations. For these groups, life is a daily hassle to access basic requirements to attend to their needs. For example,

- Across the groups, unemployment was a key challenge yet these youth must provide for food, shelter, clothing and healthcare among other basic needs; and,
- Many face housing problems and end up reverting to different sometimes risky methods of generating money. For girls, prostitution is sometimes the only easy but risk way.

“We are often evicted from houses by our landlords because we can not pay at all or pay on time. This is a big challenge for us. Some of us end up co-habiting with men but this can expose you to violence” (KII, member of CSWs, Rubavu).

Majority of youths in this category reported making a living were working casual labourers, at construction sites and other manual work where they earn about 1000 Frw per day, often not enough to cover their needs. In particular instances (Gisenyi in this case being close to DRC border) out-of-school youth reported doing cross border trade selling food commodities. Women supported by FHI who have been organized in an association called “*femme a faible revenue*” (women with weak revenue) narrated that when they take food stuffs to the neighbouring DRC, they are often confronted with the risk of being ambushed by militia groups taking away their commodities and worse still assaulting them sexually as was captured below:

“It is hard. We are forced to do cross border trading in food stuffs because we have to survive. But that carries dire risks as you can be assaulted by militias who beat you up, take away your products and even rape you. I know women who faced such odds” (KII, Femme a faible revenue; Rubavu District).

The government seeks to organize out-of-school youth into cooperatives or at least into association so that they can be provided with vocational training and other life skill. In all visited districts, the team met a number of out-of-school groups. Many of them reported having learned some new skills such as tailoring, farming among others. However their aspirations to generate income have often been hampered by lack of seed money. This was captured during key informant interviews:

“We are often helpless when it comes to buying of equipment such as tailoring machines after acquiring new skill” (KII Bugesera district)

6.3.3 School, work and activities

All respondents aged 10-19 years were in high school. One group of key informants aged 20-24 out the total twelve was composed of students from a tertiary institution. The remainder of the key informants (up to 11 groups) were composed of young adults in cooperatives/association who did not complete education due to a lack of school fees and school materials and in the case of some girls due to due to unwanted pregnancies.

6.3.4 Health and sexuality

Unwanted pregnancy and fear of being infected with HIV are the biggest youth concerns since youth reports being sexually active

Generally, youth categories interviewed demonstrated a fair understanding of health and sexuality issues although they reported certain specific challenges. Prominent issues re-emerging among groups included:

- Unwanted pregnancies among some young girls resulting into a cascade of consequences;
- Inadequate knowledge on SRH and appropriate places to seek related information;
- Limited access to contraceptives and condoms and condom none use among some youth;
- Sexual violence among vulnerable groups and sexual manipulation of the young by those older;
- Cultural barriers hindering parents to talk to their children about sexual issues; and
- Increased youth temptation to indulge in sexual practices as a result of:
 - Advancing technologies that expose youth to uncensored sexual information;
 - Increased indulgency of older people in sexual activity with younger generation often making use of resources at their disposal (sugar daddy/mummy phenomenon) ; and,
 - Increased youth desire for material things and lifestyles beyond their means

6.3.4.1 Unwanted pregnancy

Cases of unwanted pregnancy were reported by members of youth groups interviewed. Accordingly, youths start to have sex at an early age these days but generally keep it a secret because society is against young people having sex before marriage. The estimated average age of first sexual intercourse among youth was 12 years for girls and 15 years for boys — which is comparable with 2009 BSS findings which indicate that the proportion of girls and boys aged 15-19 who had their first sexual intercourse before the age of 15 was 6.1% and 14.7% in 2009 respectively⁸.

This was an indication that some youths do not use condoms although the National AIDS Control Commission, MoH and development partners have invested considerable efforts to ensure availability of condoms at different levels. Youths are often uncomfortable to seek condoms in public places for fear of being discovered to be sexually active by members of the community or even their relatives who use the same facilities.

Apart from the health centers and other outlets designated by MoH/CNLS, condoms can also be obtained from private boutiques. But again in this case, youth feel discouraged to seek for condoms from these places essentially for two reasons: 1) fear to be recognized as sexually active; 2) some youth lack the money to buy condoms which in a private boutique cost between 50 – 300 Frw.

Finally, despite youth generally having a fair amount of information about condoms, and awareness that they can be accessed with relative ease, either; off the counter or free of charge in health facilities, some youth fail to use them due to certain misconceptions and influences such as:

- That unprotected sex is more pleasurable than protected sex;
- Girls say condoms can get stuck in the vagina;
- Condoms smell bad;
- Youth under the influence of alcohol end up having unprotected sex; and,
- Rwandan girls do not actually openly consent to sexual intercourse as was captured below:

“Rwandan girls rarely openly consent to sex...and boys and girls do not sufficiently discuss it. As a result, some boys fear that the girl will change her mind during the time lapse while preparing to wear a condom (Youth Key Informant interviewee, Bugesera).

A combination of the above factors in addition to insufficient RH knowledge in general and contraceptives in particular, the ability to access them, inability of parents to openly and freely talk about sexual issues were reported as the major causes of unwanted pregnancy among the youth. Consequences of unwanted pregnancy among youth were enumerated as follow:

- Rejection of the victim by family and the person responsible for impregnating her;
- Flight by the pregnant from family;

⁸ Rwanda BSS, 2009.

- School drop out;
- Unsafe abortion with a range of complication including death;
- Early marriage;
- Premature parenthood; and
- Resorting to risky lifestyle including prostitution.

Unwanted pregnancy was reported by all youth groups interviewed as is exemplified below:

“There have been no reported cases of abortion in school but some girls have been expelled from school when they were found to be pregnant” (Focus Group Discussion, GS Shyogwe, Muhanga)

6.3.4.2 Contraceptive methods

Use of contraceptive is generally looked at as a practice for married people

The assessment found that youth was knowledgeable about modern contraception methods and when asked reeled off a number of modern methods including pills, injections IUDs, in-plants...etc. They also know that these services are provided free of charge at HC but hold misconceptions about whom the methods are meant for and the effects they cause to the consumer such as:

- Contraception is meant for adult married women;
- Seeking these methods will be interpreted as a sign of being sexually active before marriage by those who see them; and,
- Contraceptives cause serious side problems such as infertility after they are stopped.

6.3.4.3 The sugar daddy/mummy phenomenon

The sugar daddy phenomenon is a major temptation for young girls

The sugar daddy/mummy phenomenon was not such a focus data. However, results of an assessment commissioned by the MoE and conducted across 20 primary and 20 secondary revealed interesting findings⁹.

According to the findings of the above assessment, the phenomenon involves young girls and boys being enticed into sexual indulgence by much older men and women (the age of their parents); in exchange for little material things and pleasures (such as taking them out to places). It was said to be common in secondary schools, and girls were commonly affected than boys. The assessment also noted that it is common in urban than rural schools. Out of 20 secondary schools visited, interviewees from 5 reported real accounts of sugar daddy/mummy indulgence with students they new. Four out of these five schools are based in Kigali. Students also identified factors believed to be fuelling this phenomenon which included:

1. Economic factors: This is the most frequently reported factor. It was said that some students indulge in these acts, firstly because they would like to gain money, material things such as gifts (necklaces, hand sets, shoes and clothing...etc) out of it. A few get involved because their families are not able to provide for their needs. The money factor was certainly one of the most important factor— powerful enough to tempt some of the most morally upright students to indulge in the practice:

⁹ Assessment of Education Sector’s response to HIV in Rwanda; Dr David Kamugundu; Dec. 2010

“A very close female friend of mine told me that she lost her virginity to a man who offered her a large sum money” (FGD; APAPE)

Even then, money does not necessarily entirely explain all the dynamics of the phenomenon. In many of the cases, students who indulge in this practice are said to come from well to do families— able to provide for more than just essentials.

For some of them (students) it has to do with their moral conscience. Many are not even poor. They call it “removing teeth” (gukura ibyinyo) as if to highlight the efficiency with which they do it” (FGD; APAPE)

2. The **contamination effect of sugar daddies/mummies**: Peer influence is also said to be another factor. Students with sugar daddies/mummies exercise a “*contamination effect of sugar daddies/mummies*” on their friends; urging them to have sugar daddies— even going an extra step to find a sugar daddy (usually a friend of their own sugar daddy) for them. They do this by demonstrating the usefulness of the practice and pointing out how it has transformed their own livelihoods by showing off gifts acquired as is captured below:

“How can you accept to look like that, have that hair? There are guys out there are willing to provide for such needs” (FGD SICO).

3. Moral and cultural interference affects both the students and sugar daddies: Interviewed students perceived sugar daddies/mummies as people of the lowest moral standing urging all students to avoid them since they can not learn anything from people with no moral integrity. They provided counsel to young girls not to wear clothes such as mini skirts and other attires which expose their intimate body parts arguing that it attracts the attention of sugar daddies.
4. Finally, students pointed an accusing finger to the inability of parents to give children the right upbringing. They urged parents to allocate more time to their children despite work pressures. They believe that the dwindling time allocation to children by parents leaves children uninformed of the Rwandan cultural values, takes away parental counsel and sets many children on a quest to discover what is right or wrong on their own.

6.3.4.4 Sources of RH information for the youth

A. Peers, relatives and friends

Youth learn about reproductive health from different sources – formal and none formal... are likely to seek medical care in case of serious illness.

In terms of seeking help for a RH related issue, many different options were enumerated by youth respondents. And even if they all agree having been in such a situation (mainly in need of information regarding changes in their bodies during growth or more rarely, in need of medical care for a sexually related illness), the majority attested that they sought or would seek advice from their friends instead of their parents or medical personnel. Respondents reported that they would go to seek care from the health centre only if they developed a serious sexually related medical illness. However girls reported that they would seek counsel from their mothers. These were captured during the assessment as shown below:

“The first person a girl would disclose such a thing (a reproductive health issue) is her mother. Girls, (unlike boys) are open to their mothers” (KII, Female Youth Group; Nyamata Youth Centre, Bugesera District).

“I would inquire from my friends in case I developed a sexually related issue. If my friend told me that it was gonorrhoea for example, I will go to the pharmacy and tell them I am buying it for someone else...not myself” (KII, Male Youth Group; Nyamata Youth Centre, Bugesera District).

But too much trusting and reliance on peers and friends for information about SRH issues was said to carry a risk of being provided with wrong information as captured below:

“One friend of mine argued that a girl has the highest chance of becoming pregnant during menstruation” KII, Byumba Scouts.

B. Youth Friendly Centres

There was at least one youth centre in each of the districts visited. At the youth centre, youth reported being more relaxed to interact, talk and learn about sexuality issues. Two (Nyamata and Kabuga) of the three youth centres visited are supported by UNICEF, and were alive with youth activities at the time of the visit. The third youth centre in Gicumbi is supported by the National Youth Council and seemed less vibrant. Accordingly, youth interviewed in the former two centres attested having received related training, while those in Gicumbi stressed a need for training in addition to reading material. They felt they had insufficient knowledge with regards to RH issues. These youths reported that they felt unmotivated to come to the youth centre but that they went there because it is the only one available.

Since almost each district among those visited had (with the exception of Kigali) at most one youth centre, they are accessed by the youth within their vicinity. They are inaccessible to the majority of the youth in secluded locations of the district. For these youths, the only alternative service outlet remains the health centre.

C. Health centres

All four health centres did not fulfil youth friendliness settings. This is said to hamper youths from seeking services from there. For instance; the infrastructure and programs are not designed and provider not specially trained to respond to specific youth needs. This will be further elaborated in another section of this report.

D. Media

All youth also mentioned media as one of the means through which they obtain RH related information including radio and TV programs. Youth listed almost all the radios in the country in some instances naming specific programs such as Buhumuro and Bumanzi which are radio Rwanda programs, which teaches them about HIV/AIDS and conflict resolution skills. The other program specifically mentioned was the "Sinigurisha campaign" conducted by PSI Rwanda, which focused on youth and young adults. The concept behind this campaign was to raise children's awareness (especially those in the secondary schools) to the dangers of "sugar daddy/sugar mammy phenomenon" perceived to be on the raise in the country.

E. Community Health Workers

Youth also reported that they get information from community health workers. CHWs interventions however are mostly focused on adults, pregnant mothers, malaria, TB etc. In addition, seeking advice from CHWs is deemed inappropriate by youth since they (CHW) are adults with whom youth can not discuss RH issues openly.

F. School

Reproductive Health is taught in schools at primary and post primary levels as part of School health program through School Health Education Program activities but mainly as part HIV/AIDS awareness creation.

6.3.5 HIV/AIDS

The youth have appreciable information about HIV: nonetheless, the fact that some still have unprotected sex calls for more realistic approaches

Rwanda has made remarkable progress addressing the HIV challenges. Supported by outside partners, the country has been able to significantly improve the health status and HIV services of the population in the last decade¹⁰. In addition to government, there are also numerous international and national NGOs involved in the health sector in Rwanda, in particular in providing HIV/AIDS services in the districts.

Although addressing HIV challenges is a primary responsibility of the MoH and the National AIDS Commission (CNLS), other government institutions are also involved in the fight against the scourge. And therefore, in addition to treatment (currently > 80% of PLWHA in need of ARVs in Rwanda are under treatment; NSP, 2009), health education and prevention programs implemented by the health system, the MoE for example has been able to harness its normal channels of instruction to increase the level of knowledge about HIV/AIDS and RH. This is taught in form 5 and 6 primary levels and in post primary schools.

In this regard, it is noteworthy that youth groups interviewed had appreciable information about HIV. For instance, they were able to reel off facts with regards to definition, causes, symptoms, prevention and effect of HIV/AIDS.

In-school youths reported presence of anti-AIDS clubs and those who were members of these clubs not only had added information but also portrayed skills of assertiveness that was a potential facilitator in decision-making. Youths aged 10-14 years recommended abstinence as the best method of HIV prevention but majority of those aged 15 years and above regarded abstinence as unrealistic since they reported being sexually active.

Youth also identified risk factors to HIV as prostitution, multiple partners, unprotected sex and consumption of drugs like Cheap Waragi and marijuana which exposes youth to unprotected sex. Additionally, the sugar daddy/mummy phenomenon where young girls offer sex in exchange for money and other materials with richer and older men was reported by the majority of interviewees.

6.3.6 Gender

Sexual violence was reported among prostitutes who reported often being beaten by their clients. Youths also reported isolated cases of home based violence. Those who experience violence know where to seek assistance such as local administration, police and health centres for healthcare. Nonetheless, some youths decide to keep silence for fear of being exposed as rape victims.

There are no outreach programs done by HC targeting young people. CHWs mainly engage in outreach programs but their interventions are not necessarily targeted towards youth. On the other hand, services offered by health centres do not motivate young people to seek them. The services are only provided to the youth who visit the health centre a part from VCT which is sometimes done in schools.

¹⁰ Report on adolescents' health and HIV services in Rwanda, in the context of their human rights, Dr Agnes Binagwaho; 2009

6.4 Services and Health Facilities

RH services are provided to the population in general & health facilities do not fulfil youth friendly characteristics

In Rwanda health centres are open for regular work from 7 am to 5 pm. Facilities remain open after this time to provide emergency clinical services by staff on the night shift.

In the health centres assessed (much like others in the country), RH service were provided as part of the minimum service package established by the MoH. For the most part, clinics offered a range of services and commodities that included:

- Contraception with an emphasis on dual protection
- STI diagnosis and management
- HIV counselling (and referral for testing and care)
- Pregnancy testing and antenatal and postnatal care

Overall, the greatest weaknesses were counselling on sexuality and safer sex, and on sexual violence and abuse, plus post-abortion counselling and contraception (with referral for management of emergency complications when necessary) which are recommended as part of the package for youth RH services.

A range of contraceptive methods were available in the facilities visited and the managers reported never experiencing shortages of commodities. Available services are subsidized by government with support from international partners, so they are provided free of charge.

Overall, while geographic location was not a barrier to access, factors summarized below did hinder young people's ability to access RH services across visited health centres.

Provider Characteristics

- A lack of specially trained staff to address specific RH and youth needs;
- Inadequate privacy and confidentiality for youth coming to seek services; and,
- Unavailability of peer counsellors at the health facilities.

Health facility characteristics

- A lack of separate space and special times set aside for youth;
- No convenient hours are set aside by health facilities to attend to youth needs including those related to RH;
- No convenient location is designated for youth and reproductive health services; for instance youths and adults have the same waiting area;
- Inadequate space and sufficient privacy. None of the health centres visited had an adolescent ward. Sick adolescents are admitted with adults in the same wards; and,
- The surroundings are not comfortable. In the visited health centres, people passing by can easily see the waiting area and people in the waiting area. This potentially makes the youth uncomfortable to come to seek RH services.

Program design characteristics

- Health centres turn away drop-in clients if they come on another day than designated for the above mentioned RH related services;
- Prolonged waiting times were evident in the health centres assessed as a result of increased client load; and,
- The assessment did not note publicity and recruitment activities aimed at informing and reassuring youth.

Most facilities are well located and within easy reach (less than an hour's walk according to the MoH). However, the majority of clinics were not open for youth during convenient times, such as weekends or evenings. Although some of the facilities offered emergency or curative services 24 hours day, RH services were offered only during regular business hours on weekdays. There are no specific days/hours for young people yet young people feel uneasy being together with adults while waiting services. This also increases the waiting time for youth who end up giving up on the services since they are not actually sick. Fees for services posed no hindrance to the access of available reproductive health services as they are offered free of charge.

On the other hand some health centres implemented locally conceived RH service initiatives. For example at the time of assessment, Byumba health centre was implementing a program in which it offered advice to (fiancé) future couples.

In addition, Byumba oversees a peer education program supported by Imbuto Foundation (an initiative of the First Lady) in a neighbouring school. Through this program, Imbuto Foundation selected and trained Peer educators among students to mobilize the students on HIV/AIDS and VCT. The health centres and peer educators sign performance contracts which are monitored by the health center monthly.

6.5 Knowledge, perception of adults/parents on RH

Parents do not talk to their children about RH issues

Nearly all parents interviewed across four schools visited reported that they find it extremely difficult to talk to their children about reproductive health. As a result many of them reported not discussing the issues at all with their children. Being shy as a result culture set up (Rwandan culture discourages openly discussing sexual matters), lack of knowledge of the topic and a lack of time were highlighted as the main reasons. It was also reported that parents assume that children get RH knowledge and skills from school. A few parents felt that children did not want to be talked to by parents about sex and RH. They felt that children would feel suspected of being sexually active if their parents brought up such a topic for discussion with their children.

However, the majority of those interviewed expressed willingness to talk and provide advice to their children on sexual issues if they knew how best to talk to them. For instance, parents reported that they would provide the most appropriate advice such as use of condom, discuss consequences of having early sexual intercourse if their children (14 year old girls or 16 year old boys) said to them they wanted to have sex. This was captured in all FGDs with parents.

“I will consider myself a lucky parent because then I will be informed about what is happening to my child... then, I will start teaching her/him. But parents need to be knowledgeable about these issues” (Parent FGD across all schools).

Some parents though said that they would not tolerate such attitudes from their children stating that they would take necessary punitive measures against them and whoever is making sexual advances towards their children. This was captured as shown below:

“I would look for the person my son/daughter plans to have sex with and warn him/her off. If they were the same age as my child, I would talk to their parent too. If it is an older person, I will file a police case against him/her”

With the exception of one group of parents in Shyogwe Secondary school who also happened to be teachers, all the other parent groups highlighted radio programs and CHW programs as the main sources of reproductive health related information.

In addition, this group also reported having received training conducted by the Ministry of Education. A lack of reading material (documents or booklets), limited practical skills, the fact that no handouts were given out during training, and limited follow up on the training were reported as the main challenges by this particular parent group.

Interviewed parents identified service outlets where they would go to seek assistance vis-à-vis reproductive health issues as being the health centre, the local leader in charge of social affairs. A few mentioned the youth centre as an important addition to the above. Interviewed teacher parents knew additional information sources such as: Women clubs, Anti AIDS clubs, Red Cross, CHWs.

Parents with youthful children hold a mixed view of them receiving RH services without the facility having to notify them. Whereas some were against this because they felt it contravened cultural values, the majority reported that they felt happy (if the facility offers these services) about these services being offered to their children because learn how to protect themselves from certain risks. Some parents felt that health facilities were actively providing RH service to their children; it would provide parents with a starting point and opportunity to start talking to their children about RH.

The biggest aspirations of parents for children captured across board were: getting a good education, being healthy and successful schooling (intelligence in school). On the other hand, deepest fears held by parents towards children included; sugar daddies/mummy phenomenon, early sexual intercourse, temptations, having or causing an unwanted pregnancy, drug use and alcohol, and pornography.

7 CONCLUSION

Young people make the majority of Rwandan population since 67% of the Rwandans are aged less than 25 years old¹¹. As such they face an increased risk of unwanted pregnancy, STIs, and HIV/AIDS. And yet, they have been underserved when it comes to their sexual and reproductive health needs. As donors and governments begin to focus more attention on increasing the availability of RH services to young people, program managers and clinic staff need guidance on how to adapt current services so they are more youth friendly. A participatory program design and planning process would ensure that all stakeholders are involved throughout the identification of needed quality improvements and the development of implementation plans. Findings of this assessment can be applied to increase the efficiency and effectiveness of adolescent and youth focused reproductive health interventions.

8 RECOMMENDATION

8.1 Policy Recommendations

- Develop an adolescent reproductive health policy that reflects and/or addresses specific youth needs as highlighted by the assessment;
- Generate and disseminate rights charters for school and community youth areas for out of school youth;
- Continue to advocate for the right to birth control methods, and post abortion care for young girls;

¹¹ National Census – Rwanda 2002.

- Work with the Ministry of Youth to develop a youth drug policy and design strategies to rehabilitate youth on drugs;

8.2 Program recommendations

- Strengthen coordination efforts to allow creation of harmonized plans at different levels of government (supported by donors), create a strong monitoring system and use data for making management decisions;
- Work with the MoE and other partners to review education material, train teachers about RH thereby helping to adequately integrate RH within the education system;
- Design programs for out-of-school youths to improve their life skills, improve their access to income through IGA and vocational training;
- Address cultural barriers on youth sexuality and misconceptions through sensitization campaigns through media and traditional communication channels (public gatherings);
- Engage communities and parents more effectively to influence the environment outside school and involve community policing networks to identify and report sugar daddy/mummy culprits;
- Sensitize lodging/hotel and bar owners to put in place measures to deter the practice in their facilities (e.g. asking for ID of and not selling alcohol to suspected underage girls with much older men);
- Advocate for approval for use condoms in upper secondary schools and ensure their availability to students;
- Support youth friendly primary health care with more resources, develop adolescent outreach services, train community based health personnel on adolescent health and ensure that appropriate referral services are available for RH related complications;
- Disseminate reproductive health information nationally, with special highlights on adolescents' specific needs;
- Train medical staff and run awareness-raising campaigns on child and adolescent human rights and medical ethics;
- Make sure that health facility managers monitor staff for inappropriate and discriminatory behavior, and that they take action against attitudes and actions that are unwelcoming towards adolescents while rewarding those who perform proper practices towards adolescents;
- Install a system that informs adolescent patients of their rights as health facility clients and create mechanisms for anonymous complaints in order to redress problems;
- Help adolescents to assess their health needs and promote their involvement in designing and implementing programs to provide them with health services;
- Perform an analysis of health resource allocation, and assure that health resources for adolescents are spent equitably within Rwanda;
- Assess the method with which health care professionals treat adolescent patients and train them in areas that need improvement; and,
- Invite all stakeholders to assist in all the efforts listed above

9 REFERENCES

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2. Pertti J. Peltto, Professor of Anthropology (Retired): *Qualitative and Quantitative Research Methods for Understanding Issues of Masculinities, Sexuality and Gender Equity*. November 2010, unpublished work.
3. For the assessment, we have adopted the definition of young people as segmented by WHO by age into three sub-groups: (a) Young adolescents 10 – 14; (b) Old adolescents 15 – 19; (c) Young adults 20 – 24.
4. Common key stakeholders for youth reproductive health include Program managers, Health policymakers, Professional associations, Advocacy groups, Male and female community groups, Private commercial suppliers, Religious groups, Donors, Male and female representatives of the general public, NGOs
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