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EXEMPLARS IN GLOBAL HEALTH

Policy Brief

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Drivers of Success in Improving Adolescent Sexual and Reproductive Health and Rights in Rwanda

KEY MESSAGES

- Rwanda has achieved significant advancements in adolescent sexual and reproductive health and rights through effective policies and increased investments.
- Despite the progress equity challenges remain, and birth rates for 15-19 year-olds differ significantly by education attainment and household wealth category.
- Sustained political will and financial resources to provide ASRHR services and community- based interventions are vital for reaching the most disadvantaged groups of adolescents.
- Community engagement programs and media interventions have empowered adolescents, particularly girls, to challenge harmful practices such as child marriage and promote gender equality.

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INTRODUCTION

Over the past two decades, Rwanda experienced significant economic and social advancements that positively impacted adolescent sexual and reproductive health and rights (ASRHR). By 2020, GDP per capita had grown to $966, driving increased health expenditure, particularly in reproductive health, with a notable surge in family planning investments since 2008. Teenage pregnancy rates are one of the lowest on the continent and decreased from 7% in 2015 to 5% in 2020, and current use of contraceptives among adolescents and youth increased from 23.6% in 2015 to 33.7% in 2020. The proportion of adolescents remaining unmarried increased from 80% in the 2000 Demographic and Health Surveys (DHS) to 94% in the 2020 survey.

Rwanda's achievements in lowering adolescent fertility have earned it recognition as one of six study countries in the Exemplars in Adolescent Sexual and Reproductive Health and Rights (ASHER) project. This project identified LMICs that have outperformed in reducing high levels of pregnancies among those aged 15- relative to the other countries and secular trends. From these countries (positive outliers or exemplars), the project documented lessons and best practices that have been applied to improve SRHR outcomes, including preventing and managing unintended pregnancy. This policy brief highlights the key findings from the project and offers targeted recommendations to guide future policy decisions and further strengthen adolescent health outcomes in Rwanda.

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Methodology

A concurrent mixed-methods research design was employed to address the research objectives, with findings triangulated from various components. An online search conducted in August 2023 and repeated in January 2024 identified relevant ASRHR laws and policies and programs from 2000 to 2020, sourced from national government, UN agencies, and NGO websites using a targeted search syntax for Rwanda. Thirty-seven key informant interviews at national, district, and health centre levels, with senior policymakers, ASRHR program managers, representatives from Civil Society Organizations (CSOs), and community leaders were conducted. Additionally, 12 focus group discussions (FGDs) with adolescent boys and girls, disaggregated by age, marital status, school attendance, and sex, were conducted to gather views on ASRHR. These discussions explored attitudes, beliefs, and behaviours in SRHR. Quantitative insights were obtained through descriptive and multivariate regression analyses and an Oaxaca-Blinder decomposition and cohort analysis of national-level data, primarily from DHS.

Trends of adolescents' pregnancy in Rwanda from 2000 to 2020

Rwanda has observed significant changes in adolescent pregnancy rates, with the overall prevalence among youth aged 15-19 dropping from 7.3% in 2015 to 5.4% in 2020. Notably, pregnancy rates were higher among those aged 18-19 (12.7%) compared to 15-17-year- olds (1.7%), and disparities were evident based on wealth and education; the rate was 7.6% among adolescents in the poorest quintile compared to 4.3% in the richest, while only 3.4% of those with secondary education or higher experienced pregnancy, versus 15.4% among those with no formal education. The Demographic and Health Surveys (DHS) data from 2000 to 2020 highlighted a gradual decline in pregnancy rates, emphasising the need for targeted interventions for vulnerable groups, particularly those with lower educational attainment and from poorer socioeconomic backgrounds. Alongside improvements in pregnancy rates, antenatal care access among adolescents increased increased from 8% in 2000 to 41% in 2020., correlating with higher education levels, which further reinforced the connection between education and health service utilization. Skilled birth attendance among adolescents also showed a steady increase from 36% in 2000 to 99% in 2020 among adolescents who have ever given birth marking progress in improving maternal health and reducing complications associated with adolescent pregnancies.

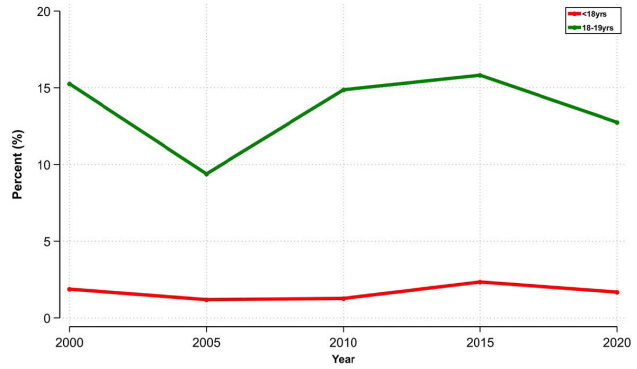

Figure 1: Changes in adolescent pregnancy in Rwanda over time (Data from 2000 to 2020 DHS by age

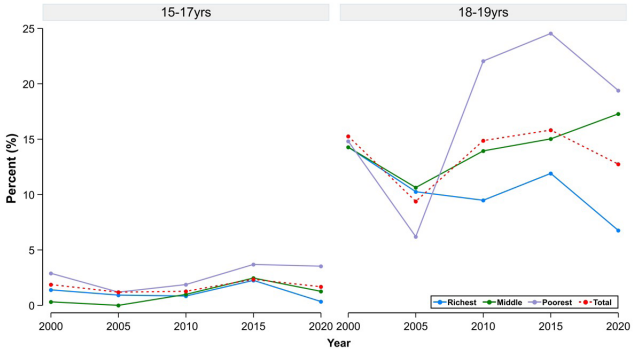

Figure 2: Changes in adolescent pregnancy in Rwanda over time by education level by age group (Data from 2000 to 2020 DHS surveys)

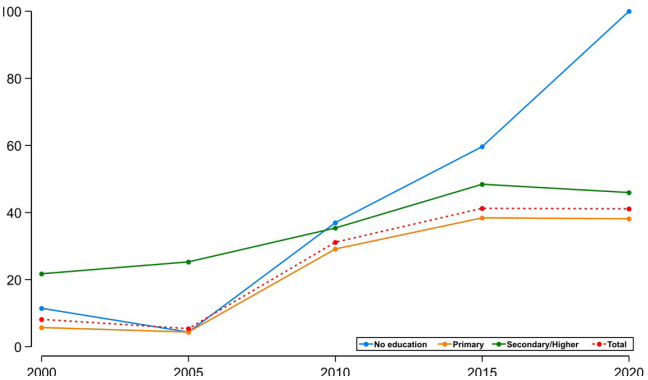

Figure 3: Changes in antenatal care among adolescents in Rwanda over time (Data from 2000 to 2020 DHS surveys) by education

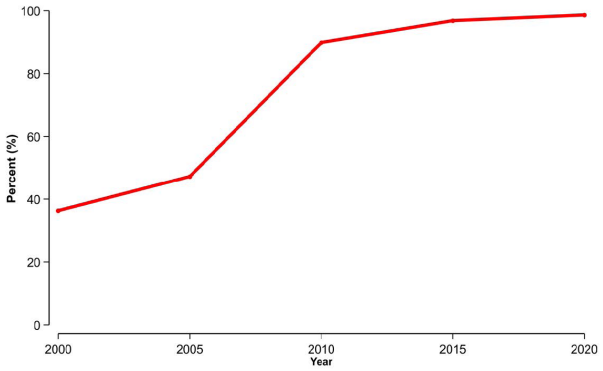

Figure 4: Changes in skilled birth attendance among adolescents in Rwanda over time (Data from 2000 to 2020 DHS surveys)

Additionally, the demand for modern contraceptive methods, along with the proportion of demand that was satisfied, increased steadily since 2000, despite some fluctuations in the 2000s. Adolescent use of implants rose over time, with slight increases also observed in the use of pills, injectables, and condoms as modern methods. The rate of adolescents aged 15–19 experiencing sexual violence declined, even as physical violence against them increased in recent years. Additionally, STI and HIV rates were higher for female adolescents compared to their male counterparts. Despite progress in gender equality, the labor force participation rate showed little improvement in terms of the gender gap, and youth not in education, employment, or training (NEET) increased nearly sixfold between 2014 and 2021.

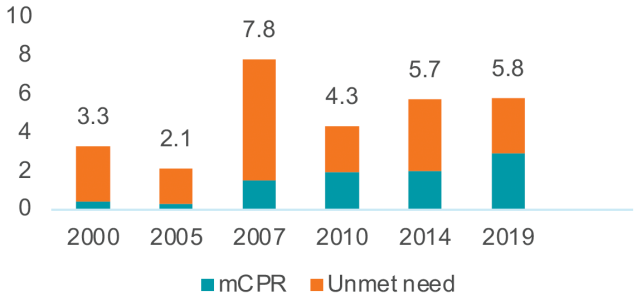

Figure 5: Total demand for modern methods of contraception, ages 15-19 (DHS)

Current use of contraception, ages 15-19 (DHS)	2000	2005	2007-08	2010	2014-15	2019-20
Implants	0	0	0.1	0.1	0.5	2
Abstinence	0.3	0.1	5.7	0.1	0.3	0.8
Condom	0.3	0.2	0.3	0.5	0.2	0.4
Injections	0.1	0	0.7	1	1.1	0.3
Pill	0	0.1	0.3	0.3	0.2	0.2
Withdrawal	0.1	0	0.1	0	0	0

Figure 6: Current use of contraception, ages 15-19 (DHS)

KEY FINDINGS

Rwanda has implemented several key policies, strategic frameworks and interventions that have significantly improved ASRHR outcomes. The key findings include:

Increase in Access to Family Planning

Rwanda's National Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) policy and Health Sector Strategic Plan IV (HSSP IV) played critical roles in advancing ASRHR outcomes. The RMNCAH policy prioritised ASRH, creating a supportive legal framework that led to the development of a Youth-Friendly Health Services (YFHS) manual and the establishment of district-level youth centres by the Ministry of Youth. These centres

provided integrated SRH services, including HIV testing, condom distribution, and mental health support, addressing the link between substance use and unprotected sex and provided SRH education through digital platforms and social media. The HSSP IV, covering 2018-2024, reinforced these efforts by integrating family planning, sexuality education, and youth-friendly services into primary healthcare, ensuring adolescents had early access to contraceptive counselling and information. It prioritised sustainable interventions that aimed at preventing teenage pregnancies and promoting adolescent health over the long term, such as community outreach, education programs, and capacity-building efforts, which empowered adolescents to make informed decisions about their SRH, thereby reducing unintended pregnancies.

Health System Strengthening

Health system investments in Rwanda were instrumental in advancing ASRHR. Expanding access to long-acting reversible contraceptives (LARCs), particularly implants, alongside comprehensive HIV programming, played an important role in maintaining low adolescent pregnancy rates. Rwanda demonstrated strong progress in meeting the demand for family planning among adolescents aged 15-19, with an 81-percentage point increase in demand satisfied. Implants were the most commonly used contraceptive method, accounting for around 70%, followed by male condoms and injections. These targeted interventions strengthened reproductive health services, ensuring adolescents had the necessary tools and resources to make informed decisions, thereby contributing to the overall progress in ASRHR outcomes.

Integrating Education Reforms with SRHR Awareness

The country consistently demonstrated low levels of adolescent sexual activity, fertility, and early marriage, with only minor decreases over time, contributing to reduced adolescent childbearing through delayed sexual initiation and marriage. Education also played a pivotal role, with high primary school attendance and low illiteracy rates driving improvements, although Rwanda lagged in secondary school attendance, showing the lowest mean years of schooling among exemplar countries. The integration of Comprehensive Sexuality Education (CSE) into Rwanda's education system, through curriculum revisions and teacher training programs, ensured that SRHR topics were included in school curricula, providing young people with age-appropriate and culturally sensitive information. Significant advancements in family planning services, particularly through an increased share of implants and access to safe abortion services, were also crucial in reducing unintended pregnancies. Rwanda achieved the highest levels of HIV/AIDS awareness and knowledge among adolescents, fostering safer sexual behaviours and mitigating STI risks. While many married adolescents made independent decisions regarding contraception and healthcare, decision-making autonomy around sexual activity remained limited, indicating a need for further empowerment in reproductive health management.

Establishment of Youth-Friendly Health Services (YFHS)

Rwanda established youth-friendly health centres and clinics across the country, providing a safe and welcoming environment where young people could access a range of health services, including SRH services, HIV testing and counselling, contraception, and mental health support. These centres facilitated a range of activities, including traditional dance classes, football teams, and art classes, which not only promoted the uptake of health services but also ensured safe and healthy recreational opportunities for adolescents. To enhance accessibility to ASRHR services, youth corners were instituted in 84% of health centres, with 99% staffed by trained personnel in ASRHR. Additionally, radio and television programs, along with call centre initiatives, were designed to reach a broad audience, including adolescents, parents, caregivers, and community members, providing valuable information, education, and resources related to ASRH. These programs covered various topics related to child development, ASRH, parenting skills, and family well-being. Talk shows and panel discussions featured experts, healthcare professionals, and community leaders to promote positive attitudes towards ASRH. Despite these advancements, challenges remained, including cultural and religious beliefs surrounding abortion and contraception, as well as geographic barriers that particularly affected rural adolescents due to insufficient adolescent-friendly training for community health workers (CHWs).

Equity in ASRH

Rwanda further demonstrated notable progress in reducing ASFR for vulnerable adolescents, with equity gaps being the smallest amongst the countries in the ASHER study and measuring below 50 across all elements. Important investments in social protection likely contributed to this success by effectively reaching the poorest adolescents. Potential explanations for the reduced equity gap among women with no education compared to those with secondary education include the effectiveness of youth corners in reaching this demographic and a higher prevalence of implant usage. However, from the last DHS of 2020, there is still a significant difference in ASFR for adolescents aged 15-19 between the highest and lowest performing groups- a 32-point difference by education level, a 40-point difference by wealth quintile, and a 12-point difference by residence.

Recommendations

To enhance ASRHR in Rwanda, the following recommendations are presented;

- Strengthen Comprehensive Sexuality Education: Revise the curriculum to engage both in-school and out-of-school adolescents, supplemented by targeted awareness campaigns.
- Enhance Access to Youth-Friendly ASRHR Services: Remove societal stigma and judgment associated with young people's reproductive choices to ensure easy access to contraceptives and reproductive healthcare.
- Invest in Community-Based Interventions: Address cultural and societal barriers that impede access to ASRHR services.
- Ensure Accurate Information Availability: Utilise diverse channels, including digital platforms, to provide reliable information on ASRHR.
- Establish an Adolescent Unit at the Rwanda Biomedical Centre: Establish a unit specifically in charge of adolescent matters at the Rwanda Biomedical Centre, Maternal, Child, and Community Health Division.
- Advocate for Political Commitment and Financial Resources: Promote sustained support for ASRHR initiatives at all government levels, emphasising the empowerment of youth-led organizations in policy-making and implementation processes.

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