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REPUBLIC OF RWANDA

MINISTRY OF HEALTH

ADOLESCENT SEXUAL REPRODUCTIVE HEALTH AND RIGHTS POLICY

2011-2015

GOVERNMENT OF RWANDA
MINISTRY OF HEALTH
MCH UNITY

TABLE OF CONTENT

Table of content **2**
Foreword **3**
Abbreviations/Acronyms **4**
Preface **7**
Acknowledgment **8**
1. Country Context **9**
1.1 background 9
1.2. family planning and fertility 10
1.3. Health Sector Analysis 11
2. ASRH&R Policy and Strategic Plan Framework **13**
2.1. definitions 13
2.1.1 Adolescents And Young Adults 13
2.1.2. Reproductive Health 14
2.1.3. Youth Friendly Sexual and Reproductive Health And Rights Services 14
3. Legal and policy status analysis **12**
3.1. International strategic commitments and goals 12
3.2. ASRH as a Right 13
3.3. National Policies and Strategies 14
4. Situation Analysis Adolescents sexual and Reproductive Health **15**
4.1. Gender Norms and Gender Based Violence 15
4.2. Education and knowledge 16
4.3. Employment, livelihoods and wellbeing 17
4.4. Adolescent and young adults Sexual and Reproductive health And practices 18
4.5. Sexual diversity 20
5. SWOT Analysis for Adolescents sexual and reproductive health Environment **20**
6. Policy and its Strategic Plan Goal **21**
6.1. General Objective 21
6.2. Specific Objectives 22
6.3. Guiding Principles 22
7. Priority Interventions **23**
7.1. ASRH&R Knowledge, Skills and Attitudes improvement 23
7.2. . improve access and utilization of SRH Products and Services among adolescents and young people 25
7.3. Enabling and Supportive Environment 25
7.4. Coordination and Collaboration 26
8. Research Monitoring and Evaluation **27**
8.1. Research 27
9. Capacity building , resource mobilization and management **27**
9.1. Resource Mobilization 27
9.2. Capacity Building and Management 28
10. Institutional Framework and Partnerships **28**
11. Conclusion **31**
12. References **32**

FOREWORD

Over the last decade, the Ministry of Health has implemented pioneering reforms in the health service delivery in Rwanda, including policies, activities, financing mechanisms, and evaluation systems. In collaboration with development partners, the Ministry of Health has invested significant human and financial resources into creating a decentralized healthcare delivery system that is rooted in equity, access, data-driven flexibility, and sustainability.

The Ministry of Health continues to move toward achieving its targets for Rwand's Vision 2020 and to buid and maitain strategic partnerships to promote relevant and sustainable interventions for the health of all Rwandans. In realizing health for all, the Ministry has added Adolescent Sexual and Reproductive Health and Rights on its list of priorities.

Through the development of this new Policy and its strategic plan, the Ministry of Health intends to evidence its commitment to the urgancy and importance of Adolescent Sexual and Reproductive Health and Rights. In the present Policy and Strategic Plan, the Ministry provides a a foundation for strategic direction to addresse the Sexual and Reproductive Health of adolescents.

The Ministry remains cognizant of the many issues that need to be addressed going forward, including the complexity of the challenges and sensitivities traditionally associated with Adolescent Sexual and Reproductive Health in the Rwandan context and indeed in all context.. The Policy and its Strategic Plan takes a pragmatic approach that incorporates Rwandan cultural values and acknowledging the genuine challenges to be confronted in the years ahead. It does not only address Adolescent Sexual and Reproductive Health and Rights but also considers the sustainable development milestones detailed in the Goverment of Rwanda's national agreements including the Vision 2020, EDPRS, and international plans of development such as the MDGs, the NEPAD, ICPD, CRC and Africa Health Strategy.

This Policy and its Strategic Plan will serve to guide interventions concerning Adolescent Sexual and Reproductive Health and Rights, particulary to respond to challenges related to HIV/AIDS and unwanted pregrancies. It has been developed at the opportune moment when Rwanda is embarking on its next phase of decentralisation, which will focus on volunteerisim. During this phase, adolescents and young adults are expected to play a major role at the forefront of this paradigm change towards a healthy and productive Rwanda for all.

To avoid creating separate and unaligned systems, the Policy and its Strategic Plan will ensure that the already existing resources such as infrastructure and human resources are harnessed and leveraged as part of a multi-sectoral and multi-disciplinary approach to meet the needs of adolescents and young adults in a youth friendly manner.

Finally, the Ministry of Health will involve its partners and stakeholders at all stage to the best inform interventions and changes downstream. Adolescents and youth will be considered partners in these efforts, as their opinions are central to creating a national response that best matches needs.

Dr Agnes BINAGWAHO
Minister of Health

ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ASRH&R	Adolescent Sexual Reproductive Health and Rights
BCC	Behavior Change Communication
BSS	Behavior Surveillance Survey
CBHI	Community Based Health Insurance
CBO	Community Based Organizations
CDLS	District AIDS Control Committees
CEDAW	Committee on the Elimination of Discrimination against Women
CHW	Community Health Worker
CNLS	Conseil National de Lutte contre le SIDA
CPAF	Performance Assessment Framework
CRC	Catholic Relief Service
DHS	Demographic Health and Survey
DPs	Development Partners
EDPRS	Economic Development Poverty Reduction Strategy
FBO	Faith Based Organization
FHI	Family Health International
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoR	Government of Rwanda
HCC	Health Communication Center
HMIS	Health Management Information System
HIV	Human Immunodefiency Virus
HPV	Human Papilloma Virus
HSSP	Health Sector Strategic Plan

ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
IEC	Information Education and Communication
IGA	Income Generating Activities
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
JADF	Joint Annual Development Forum
JHSR	Joint Health Sector Review
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIGEPROF	Ministry of Gender and Family Promotion
MINADEF	Ministry of Defense
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Economy and Planning
MINEDUC	Ministry of Education
MINIJUST	Ministry of Justice
MMR	Maternal Mortality Rate
MIJESPOC	Ministry of Youth, Sport and Culture
MoH	Ministry of Health
MSM	Men who have sex with Men
NEPAD	New Partnership for Africa Development
NGO	Non Governmental Organization
NHA	National Health Accounts
NSP	National Strategic Plan
NWC	National Women Council
NYC	National Youth Council
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PMTCT	Prevention of Mother-to Child Transmission
PSF	Private Sector Federation
RBC	Rwanda Biomedical Council
RDSF	Rwanda Decentralization Strategic Framework
RGPC	Rwanda General Population Census
RH	Reproductive Health
IDHS	Interim Demographic Health and Survey
SGBV	Sexual Gender Based Violence
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TB	Tuberculosis
TFR	Total Fertility Rate
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Oganization
TWG	Technical Working Group
USAID	United States Agency for International Development

PREFACE

Rwanda understands Adolescent Reproductive Health (ARH) as a right, that is why at the International Conference on Population and Development (ICPD) held in Cairo in 1994, more than 180 countries, including 37 sub-Saharan African countries, Rwanda signed a historic agreement committing to the Program of Action which includes the provision of sexual and reproductive health information, education, and services to adolescents (United Nations, 1994).

The formulation and development of the Adolescent Sexual and Reproductive Health Policy and Strategic Plan are key step in the implementation of our commitment. These two documents are informed by the latest findings and recommendations in Rwanda concerning services and programs, in addition to those gathered from current literature from other countries. Thus, the assessment was part of a larger process, with the Policy and Strategic Plan the ultimate goals.

More importantly, both documents reflect the urgent health needs and insufficient fulfillment of rights of young people in Rwanda. The strategic Plan further details the proposed solutions to address these issues- solutions which are rightfully owned and informed by adolescents' opinions as well as the expert views of key adolescent health and development stakeholders in government, public, private and civil society sectors in Rwanda. It is through this policy that the Ministry of health aims to realize the human right to health for all members of society, including adolescents.

Dr Agnes BINAGWAHO
Minister of Health

ACKNOWLEDGMENT

The Ministry of Health Rwanda would like to take this occasion to express its deep appreciation and sincere thanks to all who participated in the elaboration of the Adolescents Sexual and Reproductive Health and Rights Policy and Strategic Plan.

Special recognition goes to all the adolescents who remain partners in the implementation of the Policy and Strategic Plan going forward.

The Policy and Strategic Plan are informed by a mix of invaluable input and insight collected through numerous validation meetings, a situational analysis and four stakeholder workshops conducted between November 2010 and July 2011. The ministries which are with their subsectors members of the Social Cluster, the Ministry of Youth, Sports, and Culture (MIJESPOC), Ministry of Education (MINEDUC), the Ministry of Infrastructure (MININFRA), and the Ministry of Local Government (MINALOC) provided valuable inputs, IMBUTO Foundation, USAID/Rwanda, GIZ/Rwanda, UNFPA/Rwanda, IntraHealth /Rwanda, Girlhub /Rwanda, WHO , FHI/Rwanda and the Clinton Health Access Initiative deserve special mention for the financial and technical assistance provided to elaborate the policy and its strategic plan.

Finally, the Ministry of Health recognizes the invaluable work of the consultancy team and all stakeholders which contributed to the elaboration of the ASRH&R Policy and Strategic Plan.

1. COUNTRY CONTEXT

1.1 BACKGROUND

Rwanda is a largely mountainous and landlocked country of 26 338 km² in the Great Lakes region of Central Africa. It has a moderate climate an average temperature of 18°C with two rainy seasons (2000 mm). This leads to a relatively low general mortality rate, due to a climate and topography unfavorable to diseases (GoR 2007a) that impacts different living factors including those related to ASRHR. The country consists of 4 provinces and Kigali City, which are subdivided in 30 districts. Each district is divided into sectors, which are further divided into cells and finally into villages *"Imidugudu"*.

With an estimated population density of 436 persons/square km,[1] Rwanda is the most densely populated country in Africa. If unchanged, the current growth rate of 2.8% per annum will produce a population of 14 million and density of 581 persons/square km by 2020, threatening economic growth and efforts to reduce poverty. The high fertility rate is another factor fuelling rapid population growth even though all indications show that it has been declining over the last decade. The average fertility rate for a Rwandan woman in her lifetime has been reduced from 6.1 in 2005 to is 4.6 children (GoR: 2005; GoR: 2011).

Despite the decline, Rwanda's total fertility rate is still one of the highest in Sub-Saharan Africa with an immense pressure on the country's already scarce resources. Together, the high fertility rate and population density contribute to development and economic constraints, and depletion of natural resources.

Rwanda has made remarkable progress since the tragedy of the 1994 genocide, with growth in real per capita income averaging nearly five percent and accelerating to an average of nearly six percent in the last five years.[2] Rwanda nevertheless remains one of the world's poorest countries. The United Nations Development Program (UNDP) ranked Rwanda 152 out of 169 worldwide on its most recent Human Development Index (UNDP: 2010). Also, according to the most recent household survey, undertaken in 2005/6, fifty-seven percent of the population lives below a poverty line of approximately $1.30 per day, of which nearly two-thirds, or 37 percent of the total population, fall below an extreme poverty threshold of about $0.90 per day.[3] Agriculture is extremely important to the Rwandan economy. Over 90 percent of households practice some form of crop cultivation while the sector serves as the princi

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[1] This assumes an estimated population of 10,746,311 (U.S. Census Bureau, International Data Base, 2009) and a land mass of 24,668 sq/km (CIA World Fact Book).

[2] Based on data from the IMF's WEO database, October 2010.

[3] NISR, "EICV Poverty Analysis for Rwanda's Economic Development and Poverty Reduction Strategy," EICV 2005/06 Final Report, May 2007. Poverty lines are converted to purchasing power parity (PPP) using PPP values from the IMF's October 2010 WEO database.

pal source of employment for nearly 80 percent of the labor force and accounts for about one-third of gross domestic product (GDP).[4] Over the years, Rwanda has registered commendable economic growth. The service sector has accounted for the largest share of Rwanda's Gross Domestic Product (GDP), roughly 45 percent in 2007, followed by agriculture with 36 percent and industry with 14 percent at current prices.

1.2. FAMILY PLANNING AND FERTILITY

Rwanda's population is essentially young, with 67% of all Rwandans under the age of 20. In terms of gender, the 2002 Rwanda General Population Census (RGPC) shows females to be the majority (52%) while males make up 48% of the population (RGPC: 2002).

Data from Rwanda's Ministry of Health indicate that adolescents and young adults comprise the majority of Rwanda's population. For instance, young adolescents (10-14 years) make up about 17.1%, old adolescents (15-19 years) about 12.4% and young adults comprise 10.7% of the total population while another third of the population (32.1%) is under 10 years (Dr Binagwaho: 2009).

The increased use of Family Planning Methods is a major priority for the Rwandan government. Family planning prevalence among women of reproductive age (15-49 years) increased importantly from 10 % in 2005(GoR: 2005) to 45 % in 2010 (GoR: 2010). Family planning prevalence among adolescents and young adults increased equally.

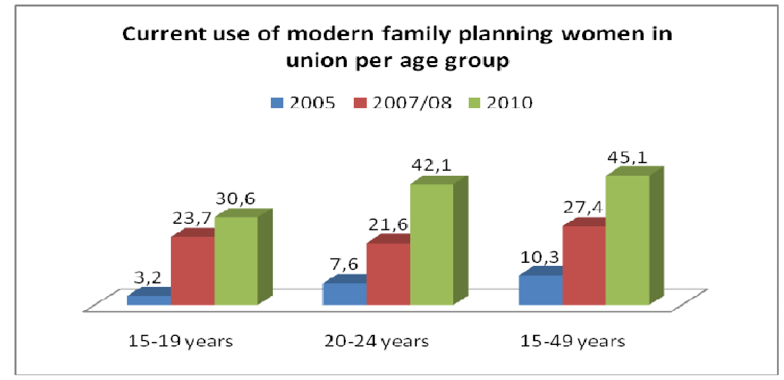
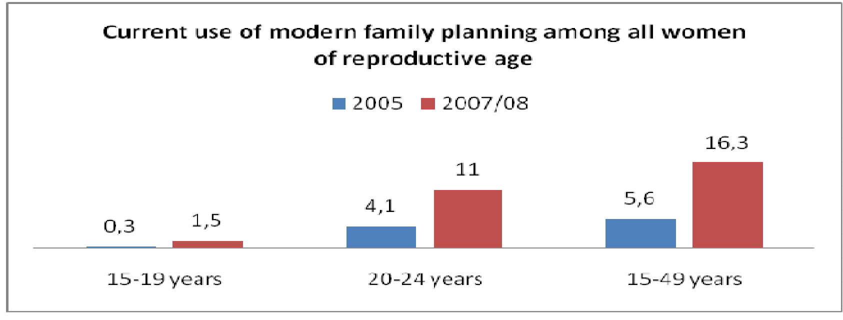


Figure 2: Current use of family planning among women in union, per age groups (GoR: 2005; 2007/2008; 2011)



[4]Labor force data comes from EICV 2005/06 Final Report. NISR estimated agriculture's share of GDP as 34 percent in 2009. In the last ten years, it has varied between 32 and 39 percent.

Figure 3: Current use of family planning among all women per age groups (GoR: 2005; 2007/2008; 2011)

The importance of the declining the total fertility rate as a potential contributor to the improvement in ASRH&R cannot be emphasized enough.

More interestingly, this has also been true among adolescents and young adults since 1992 as shown in table one below.

Table 1: Trend in Adolescent and Young Adult Fertility

Age group	DHS 1992	DHS 2000	DHS 2005	IDHS 2007/2008	DHS 2010
15-19	60	52	42	40	41
20-24	227	240	235	211	189

Age-specific fertility rates are per 1,000 women (1-36 month prior to interview)

The decline in the fertility among young adults has been more slow (211 children per 1000 young adults) compared to old adolescents during the last 15 years (40 children per 1000 adolescents) possibly because young adult age represents a period of marriage and procreation (Dr Binagwaho: 2009). Nonetheless, this trend holds enormous promise.

According to 2007/2008 IDHS, attainment of education and urbanization were the two factors most strongly correlated to reduction in total fertility rates. In light of this, women who completed secondary or higher education had the lowest total fertility rate (3.8) compared to their counterparts who completed primary education (5.7) or no education (6.1) (GoR: 2007/2008). Also, urban women had a lower total fertility rate (3.4) compared to their counterparts in the rural areas (4.8) (GoR: 2011).

On the other hand, Rwanda has made remarkable progress in reduction of child mortality and improved health outcomes. Therefore, the country must position itself to address challenges associated with increasing number of adolescents now and in the years ahead.

1.3. HEALTH SECTOR ANALYSIS

Much progress has been made in the health sector over the past decade. The infant mortality ratio decreased from 86 per 1000 live births in 2004 to 62 per 1000 live births in 2008 and to 50 in 2010 (GoR: 2006; 2007/2008; 2011). The under five mortality ratio declined from 152 to 103 per 1000 live births in 2008 to 76 in 2010. More recent data points towards remarkable improvement in maternal health (383 per 100,000 live births) (Hogan et al.: 2008) in contrast to the 750 per 100,000 live births reported by RDHS, 2005. If the rate of this decline continues, Rwanda will meet the child and maternal mortality MDG by 2015.

Considerable success has been made in combating AIDS and malaria: the HIV prevalence was 2.8% in 2008, one of the lowest in Sub-Saharan Africa; the number of severe malaria cases fell by 32.3% between 2006 and 2007 and the malaria prevalence was 2.1% in 2007. However, these two diseases still place a significant burden on the health system, and in 2008 they, along with

HIV and AIDS related opportunistic infections, accounted for 35% of hospital mortality cases (GoR: 2007/2008).

Geographical access has improved with the construction and rehabilitation of new district hospitals and health centers, but approximately 23% of patients still have to walk > one hour or > 5Km to reach the nearest health facility (HMIS: 2009). Coverage of the population by a health insurance reached an impressive 92%, with 86% of the population covered via Mutuelles, the Community Based Health Insurance (CBHI) scheme and 6% of the population covered via the health insurance for civil and military servants and their dependents.

Table 2: Key Rwandan Health Indicators

Population & Medical Personnel

- Total population: 10.7 million (U.S. Census Bureau, International Data Base, 2009)
- Per capita utilization of health facilities: 70% (HMIS, 2007)
- Doctors: 1/15,306 inhabitants (Human Resources for Health Strategic Plan, MOH 2011)
- Nurses: 1/1,500 inhabitants (Human Resources for Health Strategic Plan, MOH 2011)

Key health indicators	2005 DHS	2007/2008) (IDHS)	2010 Preliminary DHS
Neonatal mortality (per 1000 live births)	37	28	27
Infant mortality (per 1000 live births)	86	62	50
Under 5 mortality (per 1000 live births)	152	103	76
Maternal mortality (per 100,000 live births)	750	383*	Results awaited
Modern contraceptive prevalence	10%	27 %	45%
Total fertility rate	6.1	5.5	4.6

The government spending on health has been increasing since 2005 but has not reached the targets set by NEPAD (12%) and Abuja declaration (15%) of national budget allocation towards the health sector. Including the sector budget support, the percentage of total GoR budget for health was 8.3% in 2010 (Ministry of Health: 2011).

In 2006, the National Health Accounts (NHA) showed 52.5% of the Total Health Expenditure (THE) coming from external assistance. This indicates that the health sector is heavily reliant on external financing; however, there is an attempt from the government to increase its health spending as shown by the decreased proportion of external assistance to 39.9% in the THE (OECD: 2008).

There is scarcity of data regarding how much of this budget is spent on addressing ASRH&R challenges.

2. ASRH&R Policy and Strategic Plan Framework

2.1. DEFINITIONS

2.1.1 Adolescents And Young Adults

For the purpose of this Policy and its Strategic Plan, the terms adolescents and young adults have been adopted to the Rwandan context based on the following WHO definition.

Adolescents comprising of

1) Young adolescents 10 – 14 years old

2) Old adolescents 15 – 19 years old; and

Young adults comprising of

3) Young adults 20 – 24 years old.

The whole age group of 10-24 years old is young people. The ASRH&R Policy and its Strategic Plan prioritizes young people (10-24) as the primary target population.

This primary target consists of adolescents and young adults who are in- or out-of school and special groups.

In-school adolescents include adolescents and young adults in primary and secondary schools, training institutions/colleges and tertiary institutions.

Out-of-school adolescents include adolescents and young adults who have dropped out of school, never been through any formal or non-formal educational process, unemployed, engaged in local trade such as merchants in local markets and truck stops, motor and taxi services, fish mongers and other informal industries, etc.

Special groups

This Policy and its Strategic Plan takes into consideration the scope of characteristics of adolescents and young adults as heterogeneous group. Thus, addressing the unique needs presented by diverse groups of adolescents and young adults requires programs to make informed and conscious decisions to ensure projects identify the demographic mix of youth in the community being targeted for services, including: young people-living with HIV, commercial sex workers; homeless and street adolescents/youth, adolescent couples and parents, young people living with disabilities, marginalized groups such as Gay-Lesbian-Transgender (GLTBs), Orphans and Vulnerable Children (OVCs), Domestic Workers, young adult members of armed forces, displaced young adults, prisoners, migrant and mobile workers, (truck drivers, moto taxi drivers, fishermen) adolescent and young adult refugees.

2.1.2. Reproductive Health

This Policy and its Strategic Plan adopts the definition of reproductive health from the Program of Action of the International Conference on Population and Development (ICPD) which states that:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being (United Nations, 1995:30)[5].

The youth workshop conducted with adolescents and young adults on March 12th recommended definitions which have been given due consideration in this Policy and its Strategic Plan. At the workshop, Rwandan adolescents and young adults defined reproductive health as changes taking place in one's body during puberty stage (*ubugimbi/ubwangavu)* that lead to physical, psychological and behavioral changes such as development of breasts, hair (pubic and arm pit hair), enlargement of hips, menstruation, change of voice, developing attraction for opposite sex and behavior change whereby females start feeling shy. For males, specific changes associated with this period include: development in physical stature and deepening of voice.

2.1.3. Youth Friendly Sexual and Reproductive Health And Rights Services

The Policy and its Strategic Plan builds on international definitions on youth friendly Sexual and Reproductive Health services and includes recommendations from the workshop with Rwandan adolescents and young adults which includes: 1) good customer care, 2) greater integration of related services within existing health services to suit adolescents' needs; and, 3) confidentiality as the three main underlying principles to enhance these services' acceptability and accelerated uptake by adolescents and young adults.

Adolescents and young adults are not a homogenous group. Therefore youth friendly Sexual and Reproductive Health services should always be given in an age-appropriate context as well as in a gender sensitive and culturally to the Rwandan context adopted manner.

Youth friendly Sexual and Reproductive Health service consists of a comprehensive core package of services that will be integrated in the existing health service structures. This package has been defined by the Ministry of Health based on internationally recognized packages and has been adapted to the Rwandan context. It includes at a minimum the following components:

1) Information and counseling on Adolescent Sexual and Reproductive Health and Rights including

- The male and female reproductive systems
- Sexuality and the stages of sexual development
- Family Planning for adolescents
- Sexually Transmitted Infections (STIs), Human Papilloma Virus (HPV), and HIV and AIDS
- Sex, Gender, and Gender Based Violence prevention and response
- Safe Motherhood for adolescents
- Risky behavior of adolescents
- Alcohol and abuse of harmful substances
- Prenuptial Consultation
- Post abortion care
- Prenatal Consulation
- Life skills education

2) Information, Counseling and Access to Family Planning Methods

Contraceptive methods are already provided in health facilities in Rwanda. Religious health facilities which do not allow family planning products to be provided in their premises normally set up a secondary post outside the facility so that clients can access these services there. The other issue thus far has been that these services are perceived by adolescents and young adults as destined for married people as was highlighted by the rapid assessment. This Policy and its Strategic Plan emphasizes more on the importance of educating young people on the family planning concept ,which is teaching them on how they can plan for their families before they get adults and also providing Family Planning Methods to adolescents (if required particularly, emergency contraception) and availing necessary information, creating referral systems with other health facilities and community to increase follow up of adolescent and young adults clients.

3) Youth friendly antenatal care, skilled attendance at delivery, and postnatal care including management of obstetric and neonatal complications and emergencies, and prevention of abortion and management of complications resulting from unsafe abortion

In principle, the stages of pregnancy, childbirth and postpartum in young women does not differ from those in adult women. Nevertheless, young women and particularly those under the age of 20 years, have in increased risk for further complications. Health care providers working with pregnant adolescents will

- Provide young people with an early start to antenatal care and encourage them for regular ANC visits and delivery at the health facility
- Be sensitized on special problems which require particular attention among adolescents, including anaemia, poor nutritional status, malaria, HIV and other sexually transmitted infections and access to services for preventing the mother-to- child transmission of HIV
- Develop a plan for birth with the adolescent, her partner and/or family, including the place of delivery, availability of transport and the costs involved (All pregnancy related cost for ANC and childbirth are covered via the *Mutuelle*).
- Give special attention to adolescents younger than 20 years during obstetric care as they are at especially high risk of complications and death; and following delivery, to give adolescents special support for infant feeding and care and to ensure that they have access

to information, skills and services, including adequate counseling, to prevent subsequent pregnancies

- Explain benefits from postnatal care (PNC) for mother and child (reduced morbidity for newborn, improved health of mother, FP for spacing, breastfeeding etc.)
- The package for post abortion care would include :Emergency treatment of abortion complications ,Counseling and provision of services: PF testing,STI / HIV / AIDS advocacy and community mobilization for post abortion care and RH services in general

4) Youth friendly voluntary confidential counseling and testing (VCT) for HIV and prevention and treatment of reproductive tract infections and STIs including HIV and AIDS

Health care providers are trained on provision of these services and they are provided in all health facilities in Rwanda. The Policy and its Strategic Plan further emphasizes the importance of providing these services to adolescents as a specific group and make the service youth-friendly.

A wide range of services need to provide care and treatment, support and prevention of HIV and AIDS, and STIs for adolescents and young adults including Voluntary Counseling and Testing (VCT). VCT is an important entry point to prevention of HIV&AIDS. It should always be accessible and available for adolescents and young adults in a confidential, private setting free of stigmatization and prejudices and should include friendly and confidential pre-test counseling, the HIV test and post test counseling.

The management for adolescents and young adults living with HIV and AIDS is a comprehensive approach, which does not only provide medication, but also includes the following elements

- Give counseling and support to stay healthy, protect themselves and others.
- Adhere to care and treatment:
- Understand beneficiary disclosure
- Cope with stigma and discrimination
- Sexuality and reproductive health services

Nevertheless, it is important for young people to have access to health care services, which provide continuous care and support with links to other service providers and sectors. Those are e.g. collaboration to youth centers for social support, and referral to peer support, community support and specialist services.

In Rwanda, the management of an STI is generally the same between adults and adolescents and young adults. Information, education and communication (IEC) for adolescents and young adults are essential for the prevention of STI. These include:

- Mode of transmission of STIs
- Existing treatment

- Behavior Change Communication

5) Information, Counseling and Vaccination against Cervical cancer

The Cervical cancer is caused in more than 90 % by the Human Papilloma Virus which is sexually transmitted. The Government of Rwanda has settled the HPV vaccine in its routine vaccination program through a school based program and this concerns 12-15 years old girls.

Additionally it is very important to educate adolescents on the burden of the cervical cancer in Rwanda as it is the first cancer killer in women in Rwanda. Special emphasis will be given on existing ways of prevention which are delay of sexual intercourse, abstinence and vaccination.

6) Youth Friendly Prevention and Management of Gender Based Violence

GBV in of young adolescents often happens as repeated abuse. Based on the WHO head assessment (WHO: 2010) the service provider will detect signs for abuse (e.g. scars, malnutrition, school dropout, mental condition).

The management of young people does not differ in principle from the case management of adults, except adjustment of dosages for medication and special precaution to be considered regarding the age:

- If possible, the clinical examination of an adolescent GBV victim should be conducted by a provider of the same sex. If this is not possible, a person of the same sex should accompany the victim during the physical examination

- Vaginal speculum examination might be traumatic for the immature adolescent and should never be used in pre-pubertal girls. If a speculum examination is indicated (for example, suspicion of a vaginal injury or foreign body), the girl should be referred for specialist care

- All staff, including registration clerks, guards, and cleaners should be non-judgmental and should be aware of the need to ensure the privacy and respect the dignity of the victim

- Services for adolescent GBV victims should be confidential; parental consent should not be required

- Health workers should understand that sexual violence may also happen to boys and that male clients should receive the same level of clinical care and respect that female survivors receive

7) Prenuptial consultation

Providing young adults with skills to prepares for adulthood and emphasize family responsibilities, gender equity, responsible sexual behavior, positive cultural practices and

address negative ones plus providing pre-marriage medical tests and counseling. Prenuptial Consultation medical tests should include:

- General clinical exam
- Blood group with rhesus factor
- Blood pressure
- Gycemia/Glucosuria
- Renal function tests
- HIV test if necessary
- STI tests(if medically necessary)
- Hepatitis B

8) **Prenatal consultation**.

Adolescent and young people in Rwanda should feel free to search for prenatal consultations at the health center despite their marital status as it is their right. In addition to a friendly interrogatory to the teen mother. The mother should be explained at the end the family planning methods, breast feeding and baby nutrition. The clinical check up should include:

- Blood pressure
- General exam
- Diabetes
- Renal function
- HIVtest

10)**Life skills education**

Life skills are defined as abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life (WHO). The adolescence is a period that is characterized by problem dilemmas, stress, confusion and excitement. Life skills Enhances adolescents' ability to take responsibility for making healthier choices , resisting pressure and avoiding risk behavior. In life skills education, young people should actively be involved in a dynamic teaching and it should include : The skills of knowing and living with oneself; the skills of knowing and living with others and the skills of making effective decisions

Health care providers at health centers will be responsible of all activities regarding adolescent reproductive health in each health center catchment area including schools, community and at the health facilities. Selected health care providers at the health centers will be trained to offer the minimum package with special emphasis on non-verbal communication skills, active listening, and the ability to deal with sensitive topics. Additionally, the health centers will go through an assessment for possible structural adjustments, including an adolescent friendly room to create additional space for confidential counseling and examinations. The room will have adequate seating arrangements and youthful environment with posters and IEC/BCC materials while respecting synergies with the already existing structures. Hours of staff will be rescheduled to make it possible for adolescents and young adults to receive services even on weekends, in the evenings, or other times convenient for them[6]. Health centers will have weekly sessions during late afternoons, after school/ work, and additionally during weekends, or holidays. The focal point for ASRH&R in the health center should be available for communication and service delivery at any time and have to be flexible in offering appointments. Long waiting times and overcrowding should be avoided to not discourage adolescents to wait.

In each health center, a binom of two community peer educators, one male and one female, will be selected and supervised via the health center focal point.

6 Considering that adolescents and young adults are either at school or engaged in other activities during the day, health centers will be opened to times, which are convenient for them. Adolescents might find it difficult to seek help during the normal service hours of health centers unless it is an absolute emergency.

A young person has the right to consult the Youth friendly center or a Health center for reproductive health services and education. According to the capacity to youth friendly centers, schools and the community to deliver reproductive health services, clients should be transferred to the nearest health center and be given services. All sites delivering ASRH&R services should be not discriminating in any circumstances ;the environment should be appropriate and friendly to all like handicapped and HIV positive young people.

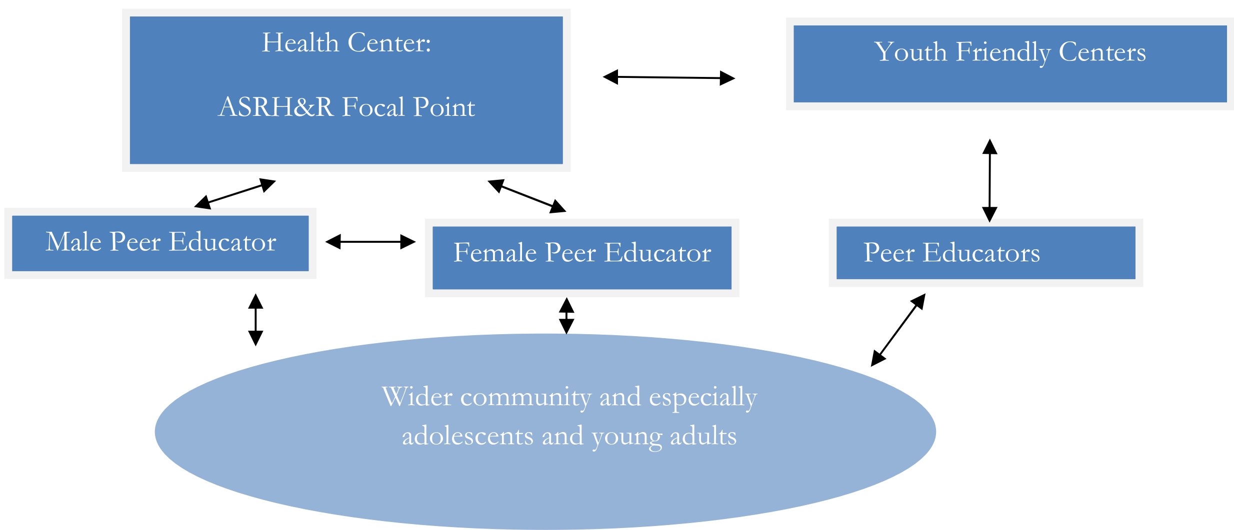


Figure 1: structure of ASRH&R Focal Points and Peer Educators in Health Centers and Youth friendly centers

3. Legal and policy status analysis

3.1. International strategic commitments and goals

Rwanda is committed to implementing international policies and achieving their goals. The directions set forth by this Policy and its Strategic Plan are consistent with the targets and goals in these policies. In particular, the Policy and its Strategic Plan specifically includes objectives that will contribute directly or indirectly to the achievement of the health-related MDGs (especially goals one; four; five and six), through: 1) eradication of extreme poverty; 2) reducing child mortality; 3) improving maternal health; and, 4) combating HIV and AIDS, malaria and other diseases.

This Policy and its Strategic Plan is consitent with Africa Health Strategy (2007–2015) in its recommendation to create Integrated Approach and Linkages. This African Health Agenda prioritizes maternal health, elimination of gender based violence, elimination of traditional harmful practices, repositioning of family planning into wider reproductive health programs, treatment of STIs, safe abortion and post-arbotion care, teenage pregancies and emphasizes the role of men, both as supporters and recipients of SRH services (African Union: 2007).

The Policy and its Strategic Plan also shall seek to operationalise Abuja Declaration's target recommendation to African countries to allocat at least 15% of the national budget to health and advocate for increased allocation of a part of these resources to ASRH&R.

3.2. ASRH AS A RIGHT

International and regional human rights bodies and mechanisms have clarified the content and implications of the right to health, which is enshrined in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESR) and in other core human rights treaties, such as the Universal Declaration of Human Rights (UDHR), or the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). These treaties are legally binding for countries that ratify them.

The following Human Rights of the Universal Declaration of Human Rights can be applied in the context of ASRH:

- **Article 2: The right of Non-Discrimination**. Adolescents, like adults, have the right to equal access to adequate health care and services, regardless of sex, race, marital or health status.
- **Article 5: The right to be protected from all forms of physical and mental abuse and from all forms of sexual exploitation**
- **Article 25: The right to health**. This includes Sexual and Reproductive Health and implies that adolescents are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so
- **Article 26: The right to education**. This includes adolescent's education and information about Sexual and Reproductive Health, to enable them to decide freely and responsibly on issues of reproduction and sexuality

The Convention on the Rights of the Child (CRC) gives young people the right to information on Sexual and Reproductive Health including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and AIDS, and the prevention and treatment of STIs (United Nations High Commissioner for Human Rights: 1989)[7].

International conferences, such as the 1994 International Conference on Population and Development (ICPD), have emphasized the importance of reproductive rights, especially for adolescents (Knudsen: 2006). They include reproductive health as a component of overall health, throughout the life cycle, for both men and women, reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice.

These international agreements developed based on increasing scientific evidence have been referred to by the Policy and its Strategic Plan to underpin the importance of ASRH&R and family planning and birth control - not only as service but as a fundamental right.

7 The Convention on the Rights of the Child has been signed by Rwanda in January 1990.

3.3. National Policies and Strategies

Rwanda's leading planning framework is Vision 2020, which is used to guide overall development in Rwanda. The Vision 2020 sets three ambitious goals to: 1) be a middle-income country having halved the percentage of people living in poverty; 2) Raise life expectancy to 55 years; and, 3) Reduce its aid dependency level; and takes cognizance of family planning as crucial for reducing both birth rates and the prevalence of HIV and AIDS. More importantly the Policy and its Strategic Plan highlight vocational and technical training in different fields targeting secondary school leavers, as well as various sections of society (with particular emphasis on youth and women).

Nested under Vision 2020 is the country's Economic Development and Poverty Reduction Strategy (EDPRS) for 2008 – 2012, the medium-term development strategy to implement Vision 2020 and achieve Millennium Development Goals (MDGs). The EDPRS singles out high population growth as a major challenge facing Rwanda, requiring innovative measures that include strengthening of reproductive health services, family planning and ensuring free access to information, education and contraceptive services in order to slow it down.

The EDPRS serves as the framework for the national Health Sector Strategic Plan II (HSSP II) for 2009 – 2012. The HSSP II outlines three strategic objectives capturing reproductive health under one of its strategic objectives that seeks to improve maternal and child health, family planning, reproductive health and nutrition.

Further, adolescent health is governed by many partially overlapping policies and several ministries including Ministry of Health, Ministry of Gender and Family Promotion, Ministry of Education, Ministry of Local Government and Ministry of Youth, Sports and Culture (Dr Binagwaho: 2009).

These institutions have developed policies to address certain health aspects of adolescents but do to address the key issues of adolescent health in a comprehensive way (Binagwaho: 2009). While the National Reproductive Health Policy and the National Youth Policy and may be the most important, a number of other policies and strategies addressing youth needs do exist as well. Those are the Health Sector Policy, the Health Sector Strategic Plan 2009—2012, the Human Resources for Health Strategy, the Behavioral Change Communication Policy the Health Sector, the Community Performance Based Financing Guide, and the National Community Health Policy.

The National Reproductive Health Policy outlines the coordination mechanism between the ministries involved and singles out Ministry of Health as the lead institution for Adolescent Sexual and Reproductive Health. It also provides an overview of adolescent health status as of 2000 by providing a SWOT analysis of RH issues and identifies key priorities as: 1) knowledge; 2) behavior change; and, 3) usage of care services related to adolescent reproductive health (Ministry of Health: 2003).

On the other hand, the National Youth Policy acknowledges the importance of health for youth in general and its impact on areas such as personal development, work and education. It also makes a recommendation for youth health programs to be developed and monitored with specific objectives to promote health, provide health related information, prevent HIV and AIDS and reduce substance abuse (Ministry of Youth: 2005). In addition, the lists strategies to reach better health outcomes among youth but remains very generic and does not offer sufficient implementation guidance.

The remaining policies developed by other ministries highlight youth but do not necessarily address adolescent health issues in an inclusive way.

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 Information, Education, Communication (IEC) procedures 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.

The Sub-Working group on ASRH&R under the Maternal and Child Health Technical Working Group in the Ministry of Health therefore developed a manual to use for training and guidance of health care providers to implement youth friendly services. Implementation of the manual will be a first major step towards youth friendly programming and youth friendly Sexual and Reproductive Health services in health centers.

4. Situation Analysis Adolescents sexual and Reproductive Health

The following chapter provides an overview on Adolescent Sexual and Reproductive Health and Rights in Rwanda and is based on the desk review, the rapid assessment, and on inputs of different stakeholder such as adolescents and youth, various government ministries and agencies, bilateral and multi-lateral development partners, civil society umbrella organizations, and national and international NGOs. In Rwanda, previous surveys and researches mainly have focused on adolescents aged 15-24. Therefore, there is a gap of existing data covering the age group of young adolescents 10-14 years old and until now, little is known about their Sexual and Reproductive Health status. The ASRH&R Policy and its Strategic Plan will fill this gap by encouraging further research.

4.1. Gender Norms and Gender Based Violence

In May 2003, Rwandans ratified a new constitution that requires the participation of women in 30% of decision-making positions. In the 2003 elections, Rwandan women earned 49% of seats in Rwanda's new bicameral legislature, through election and appointment. Since then, Rwanda has had the highest percentage of women in its legislative branch, of any country, anywhere in the world8.

[8] The Ministry of Gender and Family Promotion (MIGEPROF) has drafted a second version of the National Gender Policy and its Strategic Plan (2010) which

Gender equity is a cross-cutting issue for development policies in Rwanda in general, and it is integrated as such in the EDPRS.

However the former traditional Rwandan society created very strong gender norms and ideals, for both - men and women. These gender norms and power imbalances are especially affecting the Sexual and Reproductive Health of adolescents, since this group is for the first time in their life confronted with sexuality and many physical, biological, emotional and social changes.

They are also directly linked with the phenomenon of Gender Based Violence (GBV) 9and beliefs about masculinity support men in having multiple sexual partners and sexual risk taking (Binagwaho: 2009).

Discussion about sexuality still is a taboo topic, be it at home between parents and their children, be it a school between teachers and pupils or be it between partners, which make it difficult especially for young girls to negotiate safer sexual behaviors10.

According to the rapid assessment, young girls are more comfortable talking to their mothers than their fathers. Parent-child communication programs therefore should take advantage of already existing communication mechanisms while at the same time develop strategies on how to strengthen male involvement into all sexual and reproductive health communication.

4.2. EDUCATION AND KNOWLEDGE

Rwanda is cognizant of the value of its human capital and places education atop its ladder of priorities. According to Vision 2020, the country has chosen "comprehensive human resources development, encompassing education, health, and ICT skills, aimed at public sector, private sector and civil society" as one of its development pillars (GoR: 2000).

With the introduction of Universal Primary Education in 2003 coupled with abolishing school fees, transfer of resources directly to schools on the basis of number of pupils enrolled, in 2005; scale up of classroom contruction and introduction of mandatory double-shift class school — enrollment continued to remarkably increase and drop out to decrease.

This helped primary school enrolment to grow at an average annual rate of six per cent since 2000. National statistics show that the rate is currently at 92 per cent, with higher enrolment rates for girls also performing better than boys. The expansion has resulted in greater access to primary education particulary for the poor (Park: 2010). Earlier reports had indicated a decreasing enrollment rate particularly among girls going up the education ladder. Accordingly,

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highlights the principal guidelines on which sectoral policies and programs will be based to integrate gender issues in their respective social, cultural, economic and political planning and programming.

9 Domestic violence, the most predominant form of GBV in Rwanda. It includes forced sex in marriage, incest, sexual violence, female infanticide, and corporal punishment to children. Victims of domestic violence are often socially and economically dependent on the perpetrator (often the husband or father of the family). The 2005 RDHS showed that 31% of women reported having suffered physical violence and 35% reported having suffered some form of marital violence.

10 "(…)A girl cannot, therefore, actively say yes to sex (…). Girls have no means to negotiate safer sex. To use a condom to protect from the negative consequences of unprotected sex is not an option. Abstinence messages have reinforced the perception that to use a condom is a 'sin,' implying that the girl has actively agreed to have sex and therefore risks being labeled 'a prostitute'." In Dr Binagwaho: 2009

22.2% of females and 17.5% of males between 15-24 years have no formal school education, 66.2% of females and 67.6% of males in the same age group attained primary education while only 11.6% of females and 14.9 % of males of the same age attained secondary education (GoR: 2007/2008).

Despite the recent positive development in primary school enrollment, there are still isolated cases of school dropouts reported due to lack of school essentials and children working to support their education, according to the recent rapid assessment (MoH 2011a). According to the same assessment; adolescents and young adults interviewed reported schools to be the second most important source of RH information after friends. Therefore when children drop out of school they also miss out on a major opportunity to learn about ASRH&R.

The most recent Rwanda BSS survey further cemented education as a key factor contributing to knowledge and skills. In this survey: age, (15-19 [92%]) vs. (20-24 [95%]); residence (rural [92%]) vs. (urban [95%]) and occupation (employed [94%]) vs. (unemployed [93%]), did not seem to cause significant knowledge variation with regards to HIV and AIDS. On the other hand, wide variation in knowledge of HIV and AIDS existed between uneducated (no education at all [82%]) adolescents and young adults compared with those who completed primary (92%), vocational training (96%), secondary (98%) and higher education (99%). Only 11% had comprehensive HIV knowledge (correctly identified prevention methods for the sexual transmission of HIV and rejected major fallacies about HIV transmission) (Trac Plus: 2010). A lack of knowledge therefore leads to deep knowledge and development related consequences and impacts ASRH since education has strong correlation with ASRH&R including total fertility rates as earlier highlighted.

4.3. Employment, livelihoods and wellbeing

As notes in the assessment findings, the majority of adolescents (10-19 years) are currently in school either in primary or secondary level of education. However, young adults particularly those out-of-school, face very limited employment options due to lack of skills. The IDHS 2007/2008 highlighted employment options available to young adults: 34% were engaged as unpaid workers (e.g. field crop and vegetable farm workers), 28% as independent farmers (e.g. general farmers), 15%) as wage farmers (e.g. field crop and vegetable farm workers), 12% as wage non-farmers (e.g. maids and brick layers) and 10% as independent non-farm (e.g. sales workers or street vendors). In general only 17.8% of youth were reported to be decently employed in 2000, i.e. worked for wages in the last 12 months prior to the survey, increasing to 29.4% in 2005 (Dr Binagwaho: 2009).

For most of the unpaid young adults, life is a daily struggle to fulfill basic needs and/or responsibilities to obtain food, shelter, clothing, healthcare, or rent. Many of them additionally work as casual laborers, street vendors (illegal in Rwanda) or commercial sex workers in extreme cases (MoH: 2011a).

Indecent low paying work and worse still unemployment impacts the way these out-of-school young people live which makes them prone to vulnerability and exposed to exploitation.

4.4. ADOLESCENT AND YOUNG ADULTS SEXUAL AND REPRODUCTIVE HEALTH AND PRACTICES

Like in other parts of the world, adolescents and young adults in Rwanda are considered a healthy segment of the population. Being a particularly difficult period of puberty and adolescence where young people often try to investigate their sexuality by heterosexual relations, it exposes them to great health and sexuality challenges. These challenges include the risk of HIV and AIDS, STIs, due to inadequate RH knowledge and limited understanding about access to RH services and practices. This predisposes adolescents and young adults to risky sexual behaviors in addition to alcohol and substance abuse. Results of the just concluded assessment conducted to inform this Policy and its Strategic Plan showed that adolescent and young adult focus groups reported an increasing trend of alcohol and drug abuse among their peers (Dr Binagwaho: 2009). Alcohol and substance abuse was also underlined by the findings of the BSS 2009 in which 30% (1879/6208) of young people self reported having consumed alcohol, of which more males (45%) than females (19%) reported consuming alcohol. Regarding other drugs, 9% young people reported having tried marijuana while 6% (372/6208) reported having tried other drugs (Trac Plus: 2010).

According to the rapid assessment of adolescent reproductive health programs, most of adolescents interviewed self reported being sexually active (estimated age of sex debut: 12 for girls; 15 for boys) (MoH: 2011a). These findings are complimented by findings of the BSS 2009 which found evidence of sexual activity among adolescents even though the average age of sexual debut was much higher than the one estimated by adolescents interviewed during the above assessment. According to the BSS, the median age at first intercourse was 16 and 17 years for males and females respectively. Thirty-one percent of adolescents and young adults aged 15-25 years reported ever having sex which is a major risk to HIV and AIDS plus STIs if unprotected (Trac Plus: 2010).

The risk of HIV and STIs is further higlighted by findings of other reaserch results. According to the 2005 DHS the prevalence rate in the age group 15-19 years was 0.5% (GoR: 2005). However, young women are far more often infected than men by HIV: respectively 3.9% versus 1.1% in urban areas and 1% versus 0.3% in rural areas. The differences in HIV prevalence between men and women aged 20-24 are particularly striking: While in the 15-19 age group they are nearly equal (0.4% for men and 0.6% for women), in the 20-24 age group HIV prevalence is five times higher for women than for men (0.5% for men and 2.5% for women).

The 2007 IDHS shows that the percentage of young pregnant women who are HIV infected remains very high, particularly for the 15-19 age groups in Kigali. As per ANC 2007, overall HIV prevalence for young pregnant women aged 15-24 is 3.7% (5.1% for women 15-19 years old and 3.5% for women 20-24 years old) (GoR 2007/2008).

In contrast, the 2005 DHS revealed a low self-reported prevalence (1%) of other STIs in adolescents but highlighted a possibility of underreporting. Nonetheless, when symptoms of STIs were taken into consideration, the prevalence went up to a more realistic 4.5% among females and 3% among male adolescents. The same survey showed better knowledge of condom sources

among male, compared to female adolescents, which improved on average with increased age and educational attainment (GoR: 2005). Non-use of condoms among adolescents was captured by the rapid assessment mentioned above as a risky practice potentially favoring transmission of HIV.

According to the assessment, non-use of condoms is attributed to inability to access condoms and limitations placed on condom availability especially in schools where most of adolescents are found. However, non-use of condoms by some adolescents was also attributed to other reasons and misbelieves about condoms. Many adolescents reported that sex without a condom is more pleasurable or that condoms have a bad smell. The assessment also shows that especially girls belief that condoms can get stuck in their reproductive systems. Additionally they mentioned that Rwandan girls do not openly consent to sexual intercourse - a major obstacle to condom use[11]. The assessment also shows that alcohol influences the adolescents to have unprotected sexual intercourse which in turn sometimes led to unwanted pregnancy among adolescent girls, often leading to rejection by family; flight from family, school dropout, early marriage, premature parenthood, resorting to risky lifestyle including prostitution, and; unsafe abortion with a wide range of complications including death.

Other important challenges reported by all adolescent and young adults groups include; inadequate knowledge of ASRH&R and a lack of appropriate places to seek related information, limited access to contraceptives, sexual violence among vulnerable groups; sexual manipulation by other peers and parents not talking to children about sexual issues.

Misinformation and misconceptions identified about contraceptives by the assessment included that: contraceptives are meant for adult married women; contraceptives cause serious side effects such as infertility after termination; and, that if seen seeking these services, young people will be interpreted as being sexually active by the community. The sugar daddy/mummy phenomenon affecting mostly female adolescents is a continually emerging challenge and was reported by all youth groups particularly in secondary schools. This is attributable to economic factors (students do it to gain money, some are given gifts) while others do it due to peer influence – whereby students on influence of sugar daddies indulge their friends to do the same.

According to the assessment mentioned above, the following reproductive health programs, services and special education programs exist in Rwanda: School based Reproductive Health education, Youth Friendly Centers, peer education programs, vocational training for youth, income generating activities (IGA) for youth, HIV/ VCT counseling, mass media activities targeting young people. In the health facilities, Reproductive Health services are provided to the general population in form of contraception and family planning. However a lack of youth friendly facility characteristics including provider characteristics, health facility characteristics

11 Boys reported to be unsure of the time lapse of wearing the condom that the girl will not change her mind and therefore end up having unprotected sex.

and program design characteristics represents a major obstacle hindering young people from accessing the services.

4.5. SEXUAL DIVERSITY

There is limited information about sexual groups such as homosexuals, lesbians or commercial sex workers in Rwanda. According to the Rwanda National Strategic Plan 2009 (NSP), the extent and magnitude of the commercial sex industry remains difficult to characterize and the size of the population of sex workers in Rwanda is unknown. No representative studies have been conducted but results of mobile voluntary counseling and testing (VCT) programmatic data indicate much higher HIV prevalence among sex workers than in the general population and risk behaviors continue to be prevalent and sex work is criminalized[12]. Yet it is generally believed that most sex workers are either young adults or adolescents, despite lack of concrete data to confirm this.

Homosexuality is not illegal in Rwanda, but is strictly against societal norms, with a strong cultural resistance regarding its existence (MoH 2009b). A study conducted by Measure Evaluation in collaboration with Rwanda's Ministry of Health and its partners to explore HIV risk among MSM in Kigali, provided better understanding of the issue in Rwanda. The study revealed a number of key aspects including that the age range of respondents was 18 to 52 years with an average and median of 26 and 24 years respectively (MoH 2009c) – showing that some of these involved individuals are young adults.

In recognition of this gap, the Institute of HIV/AIDS, Disease Prevention and Control (IHDPC, former CNLS) explicitly included interventions targeting this group in the ongoing National Strategic Plan (NSP). The ASRHR Policy and its Strategic Plan shall build on these efforts to develop interventions targeting this population category among adolescents and young adults.

5. SWOT ANALYSIS FOR ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH ENVIRONMENT

Strengths	Opportunities
• Strong governmental and political commitment and will • Existence of mechanisms of intra-government and development partners collaboration (MIJESPOC Steering Committee, National Youth Commission, the Social Cluster, MoH Sub-Working Group on ASRH&R) • Governmental support for set up of associations and cooperatives at community level • Successful RH programs	• Existence of different ASRH&R, peer education and life skills programs targeting adolescents at different levels (central and community based) • Existence of decentralized structures to strengthen community based activities and socio-cultural events (e.g. Umuganda, 16 days against GBV, MCH week) • Existing Youth Friendly Centres

[12] Criminalization refers to legal regimes where sex work in itself is not illegal but many connected activities, such as soliciting for clients.

• Strong health service provision structure at all levels including Community Based Health Workers (CHW) • Availability of MoH manual for health care providers on youth friendly sexual and reproductive health services	• Existing in-school RH programs
Weaknesses	**Threats**
• Limited coordination of activities among ministries and key stakeholders • Lack of youth friendly sexual and reproductive health services and products in health facilities and youth centers	• Limited financial and human resources to implement youth friendly ASRH&R interventions at all levels • Weak coordination between stakeholders at central and decentralized level
• No specific school curricula for ASRH&R • Insufficient programs targeting out of school adolescents, young adults and high risk groups	• Insufficient advocacy for ASRH&R at central and decentralized level • Persistence of cultural barriers on ASRH&R, especially parent-child-communication and sexual education
• Lack of research on ASRH&R in Rwanda, including information on the current trend on substance and drug abuse among adolescents • Data inconsistency on ASRH&R, with regards to age groups (10-14, 15-19, 20-24)	
• Limited knowledge on ASRH&R and RH products among adolescents and adults • Insufficient age appropriate, gender sensitive and culturally accepted IEC materials on ASRH&R for adolescents and adults	

Figure 4: SWOT analysis ASRH in Rwanda

6. Policy and its Strategic Plan Goal

The goal of the Policy and its Strategic Plan is to improve the Sexual and Reproductive Health status of adolescents and young adults in Rwanda.

6.1. General Objective

To ensure that all adolescents and young adults in Rwanda have access to and use quality, comprehensive Sexual and Reproductive Health information, education, and services in a youth-friendly environment.

6.2. SPECIFIC OBJECTIVES

In order to carry out its mission, the Ministry of Health through its MCH desk has laid down the following Policy and its Strategic Plan objectives:

a) Improve reproductive health knowledge skills and attitudes by increasing the availability and access to information about adolescent sexual and reproductive health, and providing opportunities to build skills of young adolescents, adolescents and young adults

b) Expand access and utilization of quality adolescent and young adult friendly sexual and reproductive health services and products

c) Ensure equitable access and utilization of sexual and reproductive health services and products to adolescents and youth with special needs, including those living with HIV

d) Increase community and political support in the effort to create an enabling and supportive environments for adolescent reproductive health and development; and

e) Improve coordination efforts amongst key stakeholders and establish sustainability strategies for programs and services

6.3. GUIDING PRINCIPLES

In pursuit of realization of these Policy and its Strategic Plan objectives, the Ministry of Health adheres to a number of values and principles in order to fulfill the above stated mission;

1) This Policy and its Strategic Plan adopts the rights-based approach to adolescents and youth, viewing access to quality health information and services as a human right and an end itself. In this regard, the Policy and its Strategic Plan hereinto responds to the needs and aspirations of the diverse groups of adolescents and young adults taking into account their rights to access and use health information and services.
2) This Policy and its Strategic Plan recognizes that adolescents and youth are not a homogenous population. To this regard, this Policy and its Strategic Plan reinforces the need to take into account all demographic categories and scope of characteristics including vulnerability and ALL special groups, with each adolescent and youth population it serves.
3) This Policy and its Strategic Plan reinforces the ethical responsibility for privacy and confidentiality in the context of comprehensive, reliable and user-friendly programming and services for adolescents and youth.
4) The Policy and its Strategic Plan recognizes adolescents and young adults as assets, resources and partners in addressing health and development issues for ALL Rwandans. To this regard, this Policy and its Strategic Plan accords adolescents and youth the right to be engaged in programs that affect their lives; more specifically, in conceptualization, planning, implementation, monitoring and evaluation of programs addressing their own needs.
5) The Policy and its Strategic Plan builds on the Mainstreaming of gender and youth participation. The key cross-cutting issues gender and youth participation have been and will be integrated in:
    - Development and conduction of the rapid assessment of adolescents sexual and reproductive health programs, services and Policy and its Strategic Plan issues in Rwanda

- Policy and its Strategic Plan elaboration including identification of key strategic activities and costing
- Implementation
- Supervision
- Mid-term and final evaluation

6) This Policy and its Strategic Plan acknowledges the role that key stakeholders including gatekeepers such as parents, community and opinion leaders, teachers and institutions' play in adolescents and young adult's lives.
7) This Policy and its Strategic Plan acknowledges the multi-faceted and complex nature of adolescent sexual reproductive health and rights to the extent that no one approach can address ALL the unmet needs of this population. Thus, the roles - taking into account the comparative advantages - of the various stakeholders should be clearly identified, mutually agreed upon and applied to the multi-sectoral and interdisciplinary approach that will create synergy, optimize effective program outcomes and use of resources.
8) To ascertain and bring to fruition the aforementioned objectives, four major outcomes with several outputs have been developed through a series of stakeholder meetings and the assessment process. The outcomes will guide the Ministry of Health, other important line ministries and different stakeholders in refining and implementing the proposed interventions and strategies. The plan achieves this through a multi-sectoral and multi-disciplinary approach that emphasizes coordination, collaboration, prioritization, efficiency and sustainability in terms of funding, programming and research.

9) The following section outlines the Objectives, Outcomes, and Outputs. The details including key strategic activities are presented in the logical framework section of the strategic plan.

7. Priority Interventions

Four priority areas below are identified to reach stated policy objectives based on the values and guiding principles and benefit the targets (both primary and secondary) outlined above.

7.1. ASRH&R Knowledge, Skills and Attitudes improvement

The policy objective of the first priority area is to improve knowledge and attitudes by increasing the availability and access to information about adolescent health and development, and providing opportunities to build skills of adolescents, parents, service providers, community and opinion leaders and educators. In pursuit of the above policy objective, the Ministry of Health shall;

Promote and increase access to culturally acceptable, age-appropriate and gender-responsive health information and programs that will improve the knowledge of adolescents and young dults on sexual reproductive health and rights. This will in turn guide adolescents and young adults to develop socially acceptable and responsible attitudes towards sex and sexuality. The MoH shall support inclusion of comprehensive adolescent sexual reproductive health and rights education in pre-and-in-service training programs for health professionals as part of activities targeting out-of

school youth using non-formal education approaches. As part of pre-service training, the MoH shall work with the Ministry of Education (MoE) to comprehensively cover adolescent RH within the School Health Policy and support its inclusion in the school curriculum. Again the MoH shall facilitate adolescents and young adults particularly those out-of-school (who can not benefit from schools) to acquire basic skills including leadership and in other areas identified by the strategic plan. To develop and increase coverage of these skills, the Ministry will develop and use a peer education program. As the main source used by adolescents to obtain information identified by the rapid assessment, a peer education program will be set up through identification of opinion leader adolescents and young adults. Once identified, they will be trained on ASRHR counseling and deployed to disseminate RH related information to different levels including school, homes and workplace.

Further, the MoH will support programs and activities meant to sensitize opinion and community and religious leaders, politicians as well as civil society on the need to put adolescent reproductive health issues constantly on the national and local agenda.

Sensitization programs will use all the available resources and mechanisms and target all levels. The MoH will take advantage of the growing number of media outlets in Rwanda and increasing capacity of media practitioners to produce messages appropriately targeting different adolescent and young adult categories.

In addition to the media, the policy will take advantage of the available resources and structures in order to disseminate information to the lowest possible level of the community. In its Community Health Program, the MoH will provide messages in the community through a peer education program using trained voluntary adolescent and young people . They will also be working in a close collaboration with the nearest Health centers and the youth representatives at the cell level to communicate appropriate messages to parents and the adolescents and young people at home.

Another available forum which this policy seeks to leverage for greater dissemination of ASRHR related education are Ingando, and Itorero which are essentially civic education programs that bring together mainly adolescent and young adult groups usually before joining higher institutions of learning. At these forums, the MoH will design and implement education programs on ASRHR.

Finally, the ministry will keenly learn from the policy implementation process through documentation and research. As such, the MoH shall support the current health knowledge-base to include a solid platform that promotes operations research with the aim of improving the efficiency and effectiveness of adolescent reproductive health programs, services and policy in Rwanda.

7.2. . IMPROVE ACCESS AND UTILIZATION OF SRH PRODUCTS AND SERVICES AMONG ADOLESCENTS AND YOUNG PEOPLE

The policy objective of the second priority area is to expand access to reproductive health products and services in the efforts to increase utilization of comprehensive adolescent health products and services.

In pursuit of this objective, the Ministry of Health shall Integrate adolescent health services into the existing health care delivery system and expand the options available to adolescents in the area of reproductive health including substance abuse, nutrition and mental health issues. The ministry shall also enhance management capabilities of existing health facilities and staff on youth-friendly services by implementation of a related training manual for care providers, develop specific guidelines for comprehensive adolescent sexual reproductive health programs and services for use in youth-friendly centers and health facilities. A training program will then be embarked on first by creating a national trainers pool which will then roll out a training program for health care providers at the health center level to deliver youth friendly ASRH&R services. The Ministry of Health shall further strengthen services and programs in sexual reproductive health that respond to the needs of all adolescents and young adults including special groups as identified by this policy and strategic plan. The Ministry will increase availability of ASRH&R services through an expanding Community Based Provision of Contraceptive services by the trained CHWs who will (decentralize) provide those services at the Umudugudu level.

Further, the Ministry of Health shall promote harmonized monitoring and evaluation systems, documentation and the dissemination of relevant information to inform programming and services on adolescent sexual reproductive health by identifying and defining key indicators to monitor and evaluate the efficiency and effectiveness and the impact of adolescent sexual reproductive health policy.

Finally, the Ministry of Health shall strengthen the role of the private sector in adolescent sexual reproductive health programs and services to ensure full participation of all stakeholders in this program.

7.3. ENABLING AND SUPPORTIVE ENVIRONMENT

The ASRH&R policy objective of the third priority area is to increase community and political support in the effort to create an enabling and supportive environment for adolescent reproductive health and development.

For this porpuse the ministry will pursue laws as needed to ensure a safe and supportive environment for improved adolescent health and development in the areas of health, education, skill, welfare and rights, especially for the girl-child, young women and special groups of young people through sustained advocacy to cabinet and legislators. In order to ensure informed engagements with these organs, the Ministry shall accumulate scientific evidence about the need for specific adolescent reproductive health related laws.

The Ministry will promote and support policies that will enhance development and implementation of adolescent sexual reproductive health programs, protect adolescent reproductive rights and eliminate gender-based violence. The MoH shall also outline specific guidelines in collaboration with all stakeholders to provide comprehensive sexual reproductive health services and programs for adolescents and young people and ensure harmonized programming. The MoH shall also increase resource commitments for adolescent and youth health and development programs in order to achieve this policy objective.

This policy provides an opportunity to all the concerned stakeholders to seek information to help provide appropriate solutions to the increasing challenge of trans-generational sex (commonly known as sugar daddy/mummy phenomenon). Apart from providing for increased vigilance at all levels including at community level (community policing) and lodging owners, the policy encourages more scientific analysis of the problem so as to understand its root causes better. Once these are established, an appropriate remedy shall be formulated providing specific recommended contributions by level to alleviate this challenge: i.e. at the family, school, community level plus any other relevant levels — and propose restrictions and punitive measures against culprits and/or collaborators.

Finally, the MoH shall promote sensitization programs for parents and other adults in the community on the sexual and reproductive rights and health of adolescents and young adults and enhance the use of communication media and community-based organizations in advocacy and sensitization in relation to this policy and legislation for adolescent sexual reproductive health and rights.

7.4. Coordination and Collaboration

The ASR&R policy objective of the fourth priority area is to improve coordination efforts amongst key stakeholders and establish sustainability strategies for programs and services.

In pursuit of the above policy objective, the Ministry of Health shall strengthen existing coordination mechanisms for concerned ministries, departments, agencies and development partners (Donor Agencies) to provide budget lines for adolescent reproductive health programs and services.

In this light, the Ministry of health will spearhead efforts to ensure active stakeholder engagement. The efforts of the nascent ASRH&R Sub WG will be strengthened. The MoH shall also ensure joint planning involving all stakeholders to develop, finance and ensure implementation of an annual Adolescent Reproductive Health National Plan of Action.

To ensure coordinated follow up of the implementation of the program, the ASRH&R strategic paln proposes a series of indicators in addition to which the Ministry of health with its partners shall develop a harmonized monitoring and evaluation plan with core indicators, reporting

systems and involve them (partners) in joint monitoring of the RH programs through supportive supervision.

In addition to these coordination structures, the ASRH&R policy implementation will be intergrated in already existing ways that support the coordination and monitoring of assistance. A division of labor guides the placement of development assistance. The Donor Performance Assessment Framework (DPAF) helps monitor donor performance against their national-level and international commitments. There is also a Common Performance Assessment Framework (CPAF) to provide information on policy actions and performance across sectors. A Sector-Wide Approach (SWAp) is used in the health sector to ensure that all partners jointly participate in the development, implementation and evaluation of national strategic planning and policy documents, and align their contributions and programs in support of the GOR goals and strategic plans. Finally, twice per year, there is a Joint Health Sector Review (JHSR) to discuss sectoral progress and policy and budgetary priorities.

In addition, the MoH shall promote full participation of adolescents in reproductive health and development programs and services including conceptualization, design, implementation and evaluation

8. Research Monitoring and Evaluation

8.1. Research

Research is critical in the formulation and development of evidence-based policy. The strategies emerging from the policy development process guide the knowledge base which informs priorities and conceptual frameworks for adolescent reproductive health interventions.

Thus, this Policy calls for and affirms the need for a well-defined and managed platform that promotes operations research that will improve the efficiency and effectiveness of the adolescent reproductive health programs, services and policy in Rwanda.The MOH should advocate for all SRH&R adolescent and young people related researches to provide results with age desegregated . That means 10-14 years for young adolescents ; 15-19 years for old adolescents and 20-24 years for young adults

9. Capacity building , resource mobilization and management

9.1. Resource Mobilization

The MOH should ensure mobilization of significant financial, human, material and technical resources is required to attain the goal and objectives of this Policy. This responsibility will be

shared by all stakeholders engaged in addressing adolescent and youth health and development, thus keeping the principle of multi-sectoral and multi-disciplinary approach is in effect as emphasized by the Policy.

9.2. Capacity Building and Management

Adolescent sexual reproductive health and rights remains an urgent subject. In keeping with Rwanda's goals towards the Millennium Development Goals (MDGs), Vision 2020 and EDPRS as it relates to youth health and development, there is need for a modern participatory management approach to address the needs of adolescents adequately.

Through the implementation of this Policy as outlined in the institutional framework, management capabilities of the health facilities and programs at various institutions/organizations will be enhanced. The capacity building effort will be undertaken in line with the MoH guidelines and plans for decentralization, to ensure improved management systems are in place at all levels.

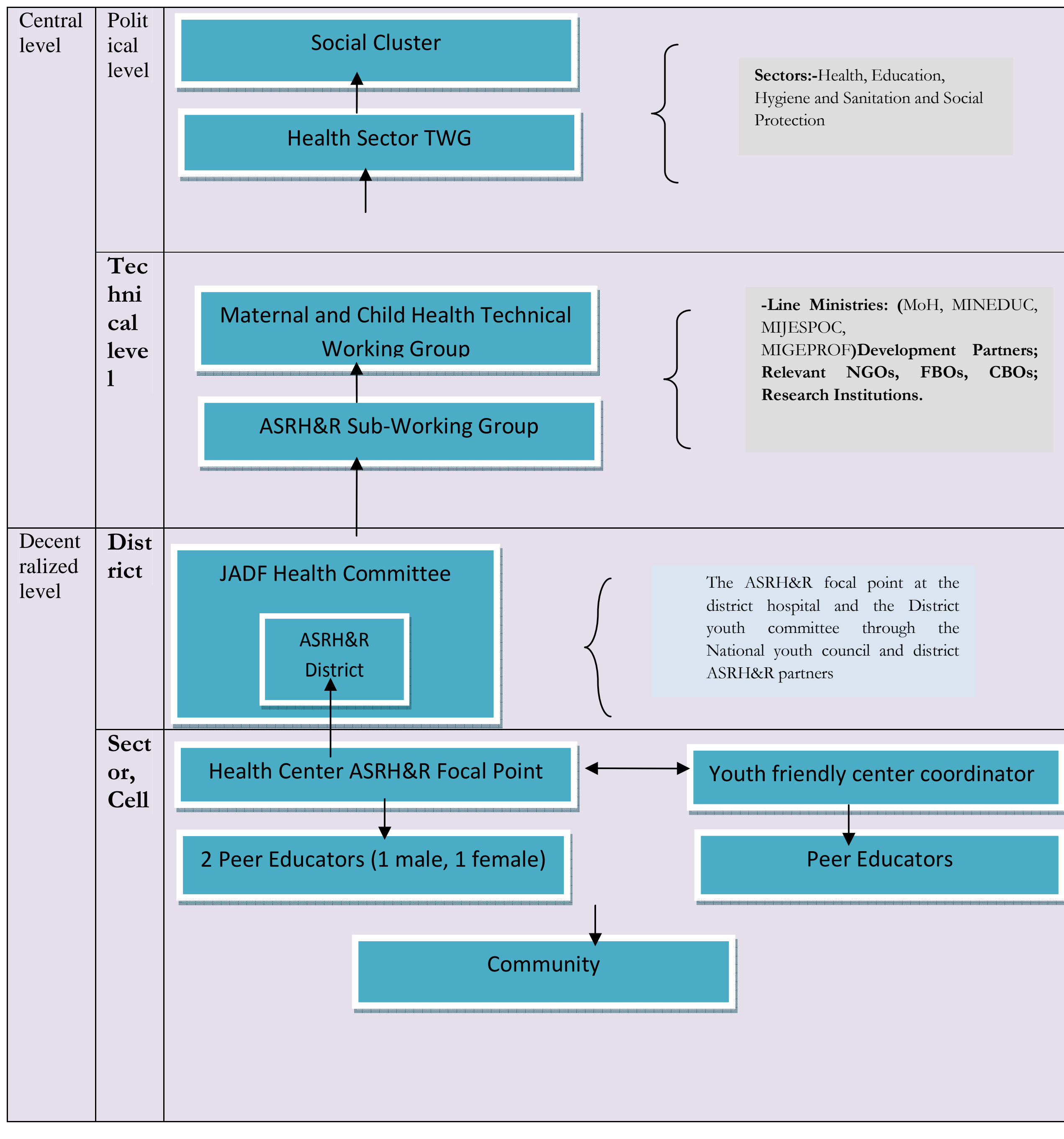
10. Institutional Framework and Partnerships

Addressing youth issues will require cross-cutting efforts and greater partnerships between ministries, their departments, development partners and local government. This section outlines key institutions that will play the principal role to ensure successful implementation of this policy. In this context, this Ministry of health shall not seek to develop new programs, mechanisms or systems. Rather, the policy shall reinforce those in place by increasing their efficiency and effectiveness. Different level will intervene at different level during the implementation of the ASRH&R policy and this will include:

The Social Cluster; the ministry of education (MINEDUC),ministry of gender and family protection (MIGEPROF),ministry of youth (MINIYOUTH),ministry of local government and social protection (MINALOC),ministry of justice (MINIJUST),ministry of defense (MINADEF), ministry of sports and culture (MIJEPOC), ministry of finance and economic planning (minicofin),ministry of agriculture and animal resources (MINAGRI),ministry in the office of the president in charge of science, technology, scientific research and information communication technologies , the parliamentarians, the National police, the UN agencies and nongovernmental organizations , the Health Communication Center (HCC) ,the central agency for the purchasing of essential drugs in Rwanda (CAMERWA), , national women council, the National Youth Council, the district ASRH&R Sub-Committee , Rwandan private sector

federation ,organizations (CBOS) and non-governmental organizations (NGOs) and also religious organizations and faith-based institutions.

The logical framework for the ASRH&R policy and strategic plan



11. Conclusion

In relation to youth health needs and efforts to address them, many adolescents and young adults in Rwanda can be identified through protective structures such as provided by families, religious and educational institutions, and employment settings. However, the lack of comprehensive, complementary, age-specific and youth-friendly information, programs and services that foster positive and protective factors has facilitated the existence of health-related gaps that can be easily addressed by this policy. For adolescents and young adults who are not within the traditionally protective settings identified above (OVCs, Street Children, Young People in Prison), the creation and assurance of protective factors remains urgent and important. This Policy aims to address existing concern are just a few of the issues that arise within the protective settings. More importantly, recognition of the role of stakeholders especially parents, family, peers and various institutions remain a vital source of health information, education and services that sustain the growth and development of adolescents and young people.

However, the need to approach the adolescent and young people population as a heterogeneous group remains the underpinning tenet upon which this Policy is written and its implementation, guided. The ASRH&R Policy takes in to account gender disparities and other forms of vulnerability of adolescents within the intervention settings including sexual and GBV, substance abuse, lack of proper nutrition, exploitation-based employment, and unfriendly-service provision.

The strategies exemplify the basic principle that young people's healthy development is influenced by positive relationships within many social environments. As noted by WHO , there are various factors that facilitate effective delivery of services and programs to adolescents and young adults. Thus, this Policy outlines targeted but broad guidelines for policy makers, program managers, and the community to move the agenda forward on provision of youth-friendly, gender-sensitive and age-appropriate comprehensive adolescent reproductive health programs and services for Rwanda's youth.

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