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ORIGINAL RESEARCH

Challenges to Accessing and Utilizing Adolescent Sexual and Reproductive Health and Rights Services in Rwanda

Michael Habtu[1], Erigene Rutayisire[1], Simonie Nisengwe[2], Solange Nikwigize[1], Domina Asingizwe[3], Naa Dodoo[4], Theoneste Ntakirutimana[1]

[1]School of Public Health, College of Medicine and Health Sciences, University of Rwanda, Kigali, Rwanda; [2]Single Project Implementation Unit, University of Rwanda, Kigali, Rwanda; [3]School of Health Sciences, College of Medicine and Health Sciences, University of Rwanda, Kigali, Rwanda; [4]African Institute for Development Policy (AFIDEP), Lilongwe, Malawi

Correspondence: Michael Habtu; Erigene Rutayisire, Email mikel.habtu@gmail.com; rerigene@gmail.com

Background: Adolescents in Rwanda, like in other developing countries in Africa, continue to face challenges in accessing and using sexual and reproductive health and right (SRHR) services despite recent progress. They lack accurate information about sexual health, which increases the risk of unplanned pregnancies, sexually transmitted infections, premature death, and unsafe abortions. Thus, our study aimed to explore the challenges that adolescents face in accessing and utilizing SRHR services in Rwanda.

Methods: This was a qualitative, phenomenological study. Twelve focus group discussions among in-school and out-of-school adolescents and 36 key informant interviews with stakeholders involved in SRHR service delivery were conducted. Data were collected using semi-structured interviews and discussion guides, supported by audio recordings and field notes. The data were analyzed using a deductive thematic analysis approach, structured around the Social Ecological Model. The analysis was conducted using Atlas ti. Version 8 software.

Results: The study revealed five themes of challenges aligned with the socio-ecological model framework: intrapersonal level (fear of being judged and stigmatization), interpersonal level (poor parent-adolescent communication and parents' lack of knowledge about SRHR), institutional level (judgmental attitude of the providers, shortages of ARSHR service providers, unsupportive environment, and long distance), community level (socio-cultural taboos and religious norms), and policy level (parental consent requirement for ASRHR access).

Conclusion: This study identified several challenges, including individual, interpersonal, institutional, community, and policy related factors. Therefore, comprehensive and multimodal interventions are needed to address the various challenges that limit adolescents' access to and utilization of SRHR information and services.

Keywords: adolescent sexual and reproductive health and rights, access, challenges, Rwanda, utilization

Introduction

Adolescents, defined according to the World Health Organization (WHO) and the United Nations, are individuals aged between 10 and 19 years.[1] It is a period of transition from childhood to adulthood, marked by significant and rapid physical, psychological, emotional, social, cognitive, and reproductive changes that affect adolescents' thinking and decision-making.[2] Globally, there are 1.3 billion adolescents, accounting for 16% of the world's population.[3] Most reside in low- and middle-income countries, where they are expected to grow faster.[4] In 2020, 250 million adolescents were estimated across sub-Saharan Africa (SSA), accounting for more than 20% of adolescents globally.[5] In Rwanda, adolescents constitute 22% of the total population, adolescents make up 22%.[6] Approximately 5% of girls and 10% of boys engage in sexual practices before the age of 15 years[7] and 2.6% of female adolescents have already given birth.[6]

Problems related to sexual and reproductive health remain a major public health concern among adolescents, particularly in SSA. Studies have indicated that early engagement in sexual activities among adolescents results in

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undesirable consequences, such as sexually transmitted infections, including HIV/AIDS, premature death, unintended pregnancy, and unsafe abortion.[8–10] Their needs are unique and are often overlooked or unmet. Adolescent Sexual and Reproductive Health and Rights (ASRHR) services are critical aspects of the well-being and future prospects of young people, as they provide the necessary knowledge and resources during their transition into adulthood. ASRHR services are fundamental within the international human rights framework, covering key aspects such as access to comprehensive and accurate education, nondiscriminatory healthcare, and autonomy in decision-making.[11]

Despite progress in recent years, access to and utilization of ASRHR services remain a major challenge, disproportionately affecting adolescent girls and boys in SSA.[12] The main barriers include cultural and religious barriers, low awareness of Sexual and Reproductive Health and Right (SRHR) services, poorly trained providers on ASRHR, common fears, embarrassment, and social stigma; negative attitudes of providers or judgmental care; lack of privacy and confidentiality; poor adolescent provider interactions; healthcare settings that lack adolescent-friendly services, availability, cost, or geographic location; laws and policies that restrict access; family beliefs; parental neglect; and lack of parent-adolescent communication in ASRHR.[13–21]

In the last decade, Rwanda has introduced various SRHR interventions to enhance access, including investment in youth corners in every health center to provide youth-friendly services, the use of media and ICT platforms, increasing licensed radio broadcasts, and featuring SRHR content on television health programs.[22] Policies and strategies regarding SRHR services have been established to support adolescent health,[23,24] through several key international and regional treaties and framework that support SRHR, including the African Charter on Human and Peoples' Rights, the Maputo Protocol and the African Youth Charter, and the International Conference on Population and Development. The treaties ratified by Rwanda have the force of law, as stipulated in Article of the 2003, revised in 2015.

Nevertheless, effectively delivering ASRHR services remains a pressing challenge, particularly in developing countries such as Rwanda, despite commitments and their availability.[25] Teenage pregnancies remain a national concern[23] and studies show that adolescents lack sufficient SRHR knowledge[26] as well as cultural norms and religious beliefs continue to be significant challenges in accessing Sexual and Reproductive Health (SRH) services.[18] However, there is limited published research in Rwanda that thoroughly explores and synthesizes the challenges adolescents encounter when trying to access SRHR services.

Furthermore, the majority of studies conducted in SSA on challenges to access and utilization of SRHR services are either adolescents or health providers only. Few studies have been conducted on barriers, including various stakeholders[13,16,18,19,21,27–29] which failed to recognize the possible connections and interactions among the essential domains using the SEM framework. Thus, a deeper understanding of the challenges from the perspectives of adolescents, health care providers, and other stakeholders involved in SRHR service delivery in the Rwandan context is needed to understand how these barriers collectively affect adolescents' access to and use of SRHR services.

To address this research gap, this study aimed to explore the challenges of accessing and utilizing adolescent sexual and reproductive health and rights services in Rwanda.

Materials and Methods

Study Setting

This study was conducted in Rwanda, a landlocked country in east-central Africa. It covers a total of 26,338 square kilometers surface area and has five provinces with 30 districts. It shares borders with Burundi to the south, Tanzania to the east, the Democratic Republic of the Congo to the west, and Uganda to the north. According to the most recent housing and population census conducted in 2022, Rwanda has a total population of 13,246,394, with adolescents aged 10–19 years accounting for 22% of the population.[6]

Study Design

We employed descriptive phenomenological qualitative research to explore the challenges in accessing and utilizing ASRHR services, using semi-structured interviews and focus group guides. The preparation, conduct, and presentation of this study were guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.[30]

This study was part of a project "*Adolescent Sexual and Reproductive Health and Rights Exemplars (ASHER) within six countries including Cameroon, Ghana, India, Nepal, Malawi and Rwanda*[31]" This project aimed to examine the policies and programs that have been successful in reducing high levels of teenage pregnancies and advancing the ASRHR.

Participants and Recruitment

The target population consisted of 120 adolescents aged 12–19 years, both in school and out of school, who participated in 12 focus group discussions (FGDs). Each group consisted of 10 adolescents. These FGDs were conducted in ten districts, two from each of the five provinces, selecting one district with the highest and one with the lowest rates of teenage pregnancies based on the HMIS reports from 2019 to 2022. The selected districts include Rubavi (high) and Nyamasheke (low) from Western Province; Nyagatare (high) and Rwmagana (low) from Eastern Province; Ruhango (high) and Nyaruguru (low) from Southern Province; Gicumbi (high) and Gakenke (low) from Northern Province; and Gasabo (high) and Nyarugenge (low) from Kigali City. In addition, one national youth center and one youth club from Kigali City, Nyarugenge District were included in the study.

The focus groups were disaggregated by age group (12–14 years, 4 FGDs; 15–17 years: 4 FGDs; and 18–19 years, 4 FGDs), school-going status (in-school and out-of-school), and gender (male and female). In-school adolescents were identified through engagement with school, whereas out-of-school adolescents were identified through local youth organizations. To encourage open and candid discussions, ten FGDs were conducted homogenous (separate for males and females), while the remaining four FGDs were heterogeneous to capture the diverse perspectives and experiences of both girls and boys.

In addition, 36 stakeholders involved in providing ASRHR services participated, including national and district government staff (n=12), representatives of non-governmental organizations (n=9), and healthcare providers (n=15). An initial inception meeting was held with the Rwanda Ministry of Health to map all relevant stakeholders, including governmental and non-governmental organizations or non-profit development partners. Consequently, a list of stakeholders involved in SRHR services was developed (Box 1). All key informants who were contacted agreed to participate. We initially planned to interview 48 stakeholders but conducted 36, as data saturation was achieved.

Box 1 Various Stakeholders Participated in the Study as Key Informants

Government organization staff (Total 12)
Ministry of Health (2 staff)
Rwanda Biomedical center
National youth council
Ministry of Youth
National child development agency
Vice Mayor Social affairs (4 staff)
In charge of Youth (2 staff)
Non-governmental organization staff /non-profit development partners (Total 9)
The Rwanda Interfaith Council on Health
Plan international Rwanda
Health Development Initiative
ENABEL- Belgium Cooperation agency

(*Continued*)

Box 1 (Continued).

United Nation Population Fund
Clinton Health Access Initiative
AfriYAN Rwanda
Save Generation Organization
Community Health Boosters
Healthcare providers (Total 15)
A nurse in charge of youth corner (12)
Directors of Health (3)

Data Collection Methods

To gather adolescents' views on their access to ASRHR services, we conducted the FGDs. On average, each FGD session lasted approximately 90 min. Additionally, Key Informant Interviews (KIIs) were conducted with diverse stakeholders involved in ASRHR service delivery (see Box 1). The interviews lasted for approximately 60 min. The interview and discussion guides were initially developed based on a review of various literature but were later adapted to the local (Rwandan) context. The tools were piloted at Bumbogo health center in Gasabo District among adolescents and healthcare providers. All guides were translated into Kinyarwanda and then back translated into English to ensure accuracy. The key research question was: *What are the challenges or barriers to accessing and utilizing SRHR services?* The guides also included topics, such as religious beliefs, social stigma, perceptions, myths, misconceptions, and policies related to the ASRHR. Besides, the basic demographic characteristics of the adolescents such as age, gender, level of education and schooling status were collected. Data collection lasted two months, from September to October 2023.

All KIIs and FDGs were recorded using a voice recorder and field notes were used to capture additional data. A moderator and note-taker facilitated each FGD session, while each KII session was conducted by one interviewer. Erigene Rutayisire (male investigator; PhD) and Simonie Nisengwe (female investigator; BSc) facilitated and supervised all the KIIs and FGDs. Their relationship with the participants was solely for research purposes. The interviews and discussions were conducted in a private, conducive environment. No repeat interviews and discussions were carried out.

Data Analysis

Audio files from KIIs and FGDs were transcribed in the local Kinyarwanda language. They were then translated into English by experienced researchers fluent in both the local language and English. Transcripts were not returned to participants for comment or correction. Thematic analysis was conducted using the six phases described by Braun and Clarke's framework,[32] which included: 1) familiarization of data, 2) generation of codes, 3) combining codes into themes, 4) reviewing themes, 5) determining the significance of themes, and 6) reporting of findings. After translation, the data were imported into Atlas ti. Software Version 8 was used for organization and initial coding. To ensure validation, two research team members -Michael Habtu (male investigator; PhD) and Domina Asingizwe (female investigator; PhD) - coded the data independently and held regular meetings to discuss discrepancies.

Deductive analysis was applied using the socio-ecological model[33] as adolescents are challenged by different ecological systems[34] when accessing and utilizing SRHR services. Thus, the analysis was structured and organized based on the SEM framework, including the intrapersonal, interpersonal, institutional, community, and policy levels.

Rigor and Trustworthiness

Efforts were made to ensure credibility and reliability of the qualitative approach used in this study. Probing questions were posed to ensure the accuracy and completeness of participants' responses. Adequate time was allocated to the

interviews and discussions to achieve data saturation. Additionally, this study applied triangulation and validation through the KIIs and FGDs of different participant groups to comprehensively explore the challenges of accessing and utilizing the ASRHR.

Prolonged interaction with the study participants guaranteed credibility. The credibility of the study was enhanced by the use of experienced and trained research assistants with backgrounds in qualitative research, integration of field notes into the data processing procedure, and frequent team meetings. Four research assistants were recruited based on their proven skills in conducting the qualitative interviews and discussions. All of them were master's holders in nursing and public health with experience in qualitative research. Team coding and audit trials were used to determine the dependability. Regular debriefing sessions and the use of reflexivity helped attain confirmability.

Ethical Consideration

Ethical approval for this study was granted by the Institutional Review Board of the College of Medicine and Health Sciences, University of Rwanda (251/CMHS IRB/2023). This study was conducted in accordance with the guidelines outlined in the Declaration of Helsinki. Informed consent was obtained from all the participants prior to participation, which included permission to publish anonymized responses and direct quotes. Privacy and confidentiality were ensured, and no identifying information of the study participants was included in data analysis. In addition, consent and assent were obtained from parents/guardian/school heads and adolescents aged < 18 years. Specific national laws, regulations, and policies govern research that involves minors. The researchers had extensive experience working with this age group and respecting the guidelines of the National Ethics Committee. We followed the best-practice guidelines for conducting research on children and adolescents.[35,36]

Results

Socio-Demographic Characteristics of Adolescents

The adolescents who participated in the study had an average age of 16 years, with the highest percentage (39.2%) falling between 18 and 19 years of age. The majority of participants were females, accounting for 63.3%. In terms of educational level, 40.0% of the adolescents were in Grades 7 and 9 (Table 1).

Using the Social Ecological Model (SEM) framework, themes that emerged from the interviews and discussions were organized into five main categories: intrapersonal/individual, interpersonal, institutional, community, and policy-level

Table 1 Socio-Demographic Characteristics of Adolescents

Variables	N=120	%
Age [years]		
12 to 14	40	33.3
15 to 17	33	27.5
18 to 19	47	39.2
Means (Standard deviation) = 16 ± 2.4		
Gender		
Female	76	63.3
Male	44	36.7
Level of education		
Grade 3 to 6	36	32.7
Grade 7 to 9	44	40.0
Grade 10 to 12	30	27.3
In school/out of school status		
In-school	60	50.0
Out of school	60	50.0

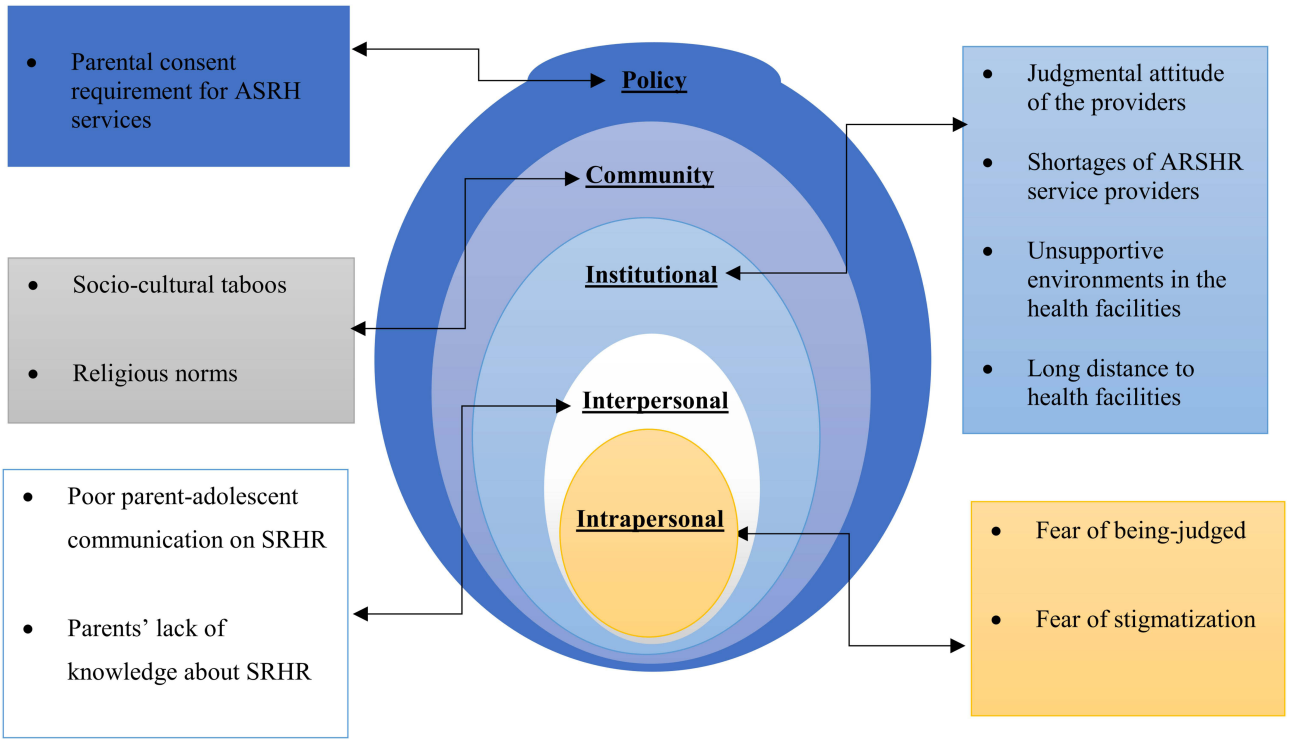

Figure 1 Challenges to access and use ASRHR services among adolescents using Socio-Ecological Model framework.

challenges. Figure 1 presents the detailed challenges in accessing and using ASRHR services among adolescents, using the Socio-Ecological Model framework.

Challenges at Intrapersonal/Individual Level

Fear of Being Judged

Most of the adolescents who participated in the study expressed a deep fear of being judged by others, including family members, which prevented them from seeking the services they needed. This fear of embarrassment stems from concerns that others might label them as promiscuous, engaging in inappropriate behavior, or engaging in risky sexual behaviors such as prostitution. Consequently, the pressure to conform to societal expectations and avoid judgment often leads to avoidance of SRHR services. Some participants expressed:

> It is not easy to access reproductive health services because sometimes you feel ashamed or embarrassed to ask for them. (FGD-12, Females 12-14 years)

> We are afraid of being seen while accessing SRHR services; hence, we avoid seeking them even we wants to. (FGD-10, Both Females and males 15-19 years)

> There is information I would not ask about SRH at the health center because of the person I might encounter, I would feel too ashamed to ask. (FGD-7, Females 12-14 years)

> Our concern is that we feel like everyone will know and see that we have gone to seek reproductive health services at health facilities' (FGD-2, Males 15-19 years out of school)

Fear of Being Stigmatization

Similarly, most stakeholders reported that adolescents often feel ashamed when seeking SRHR services, and that this feeling of shame is closely associated with social stigma.

There are some young people and adolescents still feel guilty and ashamed for accessing available and affordable SRHR services provided by youth centers and youth corners. (KII, a government staff)

Challenges hindering adolescents from accessing reproductive health services includes stigma associated with seeking such services. (KII- a non-governmental organization staff)

Young people may be afraid and say that if I go to the youth centers, someone will see me asking for a condom and call me a prostitute. (KII, a nurse in charge of youth corner)

Challenges at Interpersonal Level

Parents' Lack of Knowledge About SRHR

It has been reported that due to the lack of knowledge and understanding of SRHR services, most parents are unable to provide their children with accurate and comprehensive information regarding SRHR.

Parents are lacking knowledge about sexual and reproductive health issue and they may not effectively communicate this information to their children. (KII, a government staff)

The possible obstacles are that the parents do not understand SRHR, and if the parents do not understand it; it takes time for the child to receive the right service and information. (KII, a health director)

Parents need awareness so that they can have knowledge about reproductive health so that they can train us about sexual and reproductive health. (FGD-3, Females 15-19 years out of school)

Poor Parent-Adolescent Communication on SRHR

During the discussion and interviews, participants indicated that parents did not communicate with their adolescents regarding SRHR issues. They fear that communication regarding SRHR will lead their adolescents to engage in sexual activities. Parents believe that when their children seek these services, the information provided is not meant to protect them but rather encourages or exposes them to bad things or misbehavior. As a result, parents still resisted parent-adolescent communication regarding SRHR.

When it comes to sexual and reproductive health, our parents do not share with us any information about reproductive health. This is because we have not had such conversations with our parents for a long time and now we feel too ashamed to talk to them. (FGD-5, Both Females and Males 15-19 years in school)

Some parents choose not to talk with us about reproductive health because they often think that we are going to engage in sexual activity, which is a reason to hide information from us. (FGD-9, Females 15-19 years)

There are parents who ask us never to talk about SRH with adolescents, claiming that the messages we provide are sinful. They believe that if they do not discuss SRH with their children, the children will avoid sexual activities, and therefore, they will not face any danger. (KII, a health director)

The obstacles are mainly related to the way we grow up, because the parents most of them are a bit older and may not understand that teaching about reproductive health is important. There are those who think also teaching about SRH will make young people adopt bad attitudes. (KII, a nurse in charge of youth corner)

Challenges at Community Level

Socio-Cultural and Religious Norms

It was noted that in Rwandan sociocultural and religious contexts, discussing or talking openly about ARSHR topics is still considered taboo. Due to cultural influences, adolescents avoid accessing SRHR services because they view them as ungodly.

A person who attempted to discuss topics related to sexual and reproductive health was considered to have poor behavior or lack cultural values. (KII, a health director)

> In our culture, you cannot talk openly about sex or sexual reproductive health in general. Therefore, this makes us to look for information elsewhere, which make many youth to get wrong information. (KII- a non-governmental organization staff)

> There is religious believe, some adolescent due to influence of churches, they think that getting access to information is ungodly activities, which lead to not coming in the health center for ASRHR information and services. (KII, a nurse in charge of youth corner)

> Well, when it comes to religious people, especially Catholics who own many schools, health centers and hospitals, they do not agree to provide youth-friendly services. As a result, young people need these services and go to the nearest facility; they are unable to access them. (KII, a nurse in charge of youth corner)

Adolescents also indicated that people who perceive talking about SRH as inappropriate for their context or setting consider it to be a foreign culture. Furthermore, it has been reported that if community members notice adolescents going to youth centers, they immediately perceive that they are engaging in bad behavior or inappropriate actions.

> The perception of the people about reproductive health services is that they consider it as something that kills the culture and they consider it as a foreign culture that is not suitable for Rwandans while they need these services. (FGD-5, Both females and males 15-19 years in school)

> The attitude of the people living in this area when they see you going to the youth center, they immediately start saying that you are having sex at a high rate or prostitute. (FGD-10, Both females and males 15-19 years)

Challenges at Institutional/Organizational Level

Judgmental Attitudes of Healthcare Providers

It was noted that health care providers, particularly nurses, have a negative judgment towards adolescents when they need SRHR services. They were reported to call them derogatory names or to question why they wanted these SRHR services at a young age. This was confirmed by stakeholders, who indicated that providers were not welcoming to adolescents because of their judgmental attitudes.

> There are some health care providers who give you poor services and talk to you disrespectfully, asking why you are behaving badly at young age. (FGD-10, Both females and males 15-19 years)

> I would like to share the story of my girlfriend. She went to the provider for test when she was pregnant. The health care provider told her very badly, "Why are you starting to engage in sexual activities, you are a child from a poor family and you are still young". The girl was saddened by the doctor's judgement. (FGD-9, Female 15-19 years)

> You find that there are young people who go to seek services, but the service provides them starts judging them instead of offering the needed help. For example, the nurse say, 'at your age, you are starting to have sex" which can discourage the young person from returning to the youth corners. (KII- a non-governmental organization staff)

> Despite ongoing efforts to train healthcare providers, many still harbor a judgmental attitude towards adolescents and young people seeking access to ASRH services. (KII- a non-governmental organization staff)

Shortages of ARSHR Service Providers

The participants highlighted an insufficient number of adequately trained staff and limited human resources for SRHR services. Sometimes, individuals seeking SRHR services arrive when providers are occupied by other services. Consequently, they experience long waiting times, become fatigued, and ultimately leave without receiving the required services. It was noted that even some facilities do not have nurses at all.

> The first challenge is shortage of staff, and this can lead to the delay of the service provision, because maybe the one who was supposed to provide counseling as sometimes nurses are allocated to work in other services. (KII, a nurse in charge of youth corner)

> Accessing SRHR services can be a challenge for some young people due to shortages of staff. Limited time for counseling and services upon the young people arrival adds to the challenge. (KII, a health director)

> If you look at it in general, the youth center that has reached the regional level face some obstacles because they need enough staff to provide all the necessary services. However, there are still problems with shortage of staff. (KII- a government staff)

> Even in some places, you may find these services are not well provided and there are other youth centers where you can find no nurse for the service provision. (KII, a nurse in charge of youth corner)

In addition, to enhance accessibility and promote task shifting among nurses, telemedicine was proposed for implementation. Additionally, an online platform could be used to share SRHR information, considering that most young people use phones, which helps ensure wider access to information.

> New guideline of telemedicine is not yet implemented but studies showed that there is a possibility to do task shifting to nurses. This will help in accessibility of services. (KII- a government staff)

> One thing I would like to say is that you see a lot of young people with phones, both students and non-students. They should create an online platform that provides information for everyone to access reproductive health information without having to go to the health setting. (KII, a health director)

In addition, it was recommended that older people providing SRHR services should be replaced with younger people because they feel more comfortable asking questions freely or seeking reproductive health services, as they are more trusted or better understand adolescents' reproductive health issues.

> The health counselors we have in this area where we live are old. Thus there is a need to include young health counselors so that young people can go and ask freely for services. (FGD-2, Males 15-19 years out of school)

> Instead of including an older person when they have a young one, they should include a young nurse as the teenagers can feel comfortable and free. (KII, a nurse in charge of youth corner)

> What I think should be done is that people who provide services should include young nurses in every health center. (KII- a government staff)

Unsupportive Environments in Health Facilities

Participants pointed out that a lack of privacy due to open spaces or insufficient infrastructure in health facilities significantly discouraged adolescents from seeking SRHR services. The absence of private spaces or discrete service areas contributes to a sense of insecurity, further deterring adolescents from seeking help.

> Youth corners are located in an exposed place, where you enter and everyone sees where you are going and get to know what is being done there, some teenagers will not go there because they will be afraid to meet a member of their family like an aunt or a grandmother that came for ordinary health care. (KII, a health director)

> You can see even those coming for antenatal care, the consultation room is just opposite the youth corner. This is an obstacle to the use of youth services. (KII, a nurse in charge of youth corner)

> A key challenge is inadequate infrastructure, as the space is limited and the buildings are small. The same building that contains everything including ASRH, which lacks privacy. (KII, a nurse in charge of youth corner)

> Our concern is that reproductive health services are provided at the health facility where you go there and everyone sees you. (FGD-9, Females 15-19 years)

> Young people need youth rooms in a different place so they can get the reproductive health information they need freely. (FGD-3, Females 15-19 years out of school)

Long Distance to the Health Facility

The majority of stakeholders and adolescents indicated that the long distance to access SRHR services is a key barrier. They stated that many adolescents, particularly those in rural areas, walk long distances to access services as they live far away from health facilities.

> Access to reproductive health services is easy for some but difficult for others. Because there are adolescents and young people who live far from health centers. (FGD-3, Female 15-19 years out of school)

> Some young people come to the health facilities for SRH services, while others who are located far away from the facilities, are unable to access SRHR services. (KII, a health director)

> Biggest barrier we have is geographical issue; many adolescents walk a long journey to health center for youth friendly services, which is the biggest challenge. (KII, a nurse in charge of youth corner)

> In rural areas, it is difficult, because there is a problem of access to SRH information due to the nature of the area, but as young people who live in cities, there is accessibility. (KII- a government staff)

Challenges at Policy Level

Parental Consent Requirement for ASRHR Services

The majority of stakeholders indicated that the requirement for parental consent was considered the key barrier to accessing and utilizing SRHR services. They recommended removing this requirement and stating that adolescents should not be asked to provide parental consent.

> Parental consent is a problem, as sometimes the parent is the one to bring the adolescent to the facilities. So, if the parent does not agree with what you are going to do, it becomes difficult. (KII- a non-governmental organization staff)

> The specific thing that can be done, perhaps is to establish laws that help everyone who needs SRH service to get them without the approval of parental or guardian. (KII- a non-governmental organization staff)

> For reproductive health services, the law must determine services allowed to the youth without parental consent. This is an important aspect that should be considered. (KII, a nurse in charge of youth corner)

> SRH services are not encouraged for adolescents because they require parental presence or consent to access them. If adolescents must have their parents around, it does not seem like real encouragement. (KII- a non-governmental organization staff)

However, one participant indicated that the law of parental consent was no longer a requirement, as indicated in the recent training. However, this has not yet been announced as a national policy.

> Now, according to the new government regulations, adolescents can come on they own without the permission. We were informed during a recent training that requiring parental consent is no longer allowed, as it is based on the child's won will. (KII, a nurse in charge of youth corner)

Discussion

Adolescents have the basic human right to access information on SRHR,[37] which helps them reach their full potential and development.[38] However, access to SRHR during adolescence has become a global concern despite government and policy commitments to improve adolescent health. This study explored the challenges faced by adolescents in Rwanda in accessing and utilizing SRHR services. This study revealed multiple interconnected challenges to SRHR service access, spanning intrapersonal/individual, interpersonal, institutional, community, and policy-level factors.

At the individual level, fear of being judged or stigmatized by the family, community, and healthcare providers was identified as a critical challenge restricting adolescents from accessing SRHR services. This finding is in line with other studies[18,21,27,39–42] where fear of stigma or criticism from various bodies, including families, peers, the community, and

health providers, make adolescents not using SRHR services. These perceptions could be rooted in personal and socio-cultural beliefs[43] and are documented as a powerful barrier, hindering adolescents and individuals from seeking services.[19] Thus, it is crucial to establish SRHR services at accessible locations such as school-based programs, youth clubs, and community volunteer initiatives.[42]

At the interpersonal level, poor communication between parents and adolescents about sexuality issues, influenced by cultural norms or a lack of skills, is a key challenge to adolescents' access to SRHR services. Similarly, poor parental communication and lack of open discussions about ASRHR have been documented in various studies, particularly in SSA.[27,41–43] As supported by other studies, parents are mistakenly concerned that SRH education may encourage sexual activity among adolescents is supported by other studies.[43–45] Although parents believe that they are protecting their children by avoiding discussions about sexuality, they may hinder their ability to make autonomous decisions regarding SRHR. Parents often view sexual activity as inappropriate, shameful, and morally unacceptable, which hinders open discussion about sexual health with their children.[46] In addition, parents' lack of knowledge and understanding of SRHR prevents them from providing accurate information to their children, a finding that is consistent with other studies.[43,46] Therefore, there is a need to engage and empower parents by equipping them with SRHR information to provide them with accurate information and guidance.

At the community level, as observed in other studies in SSA, sociocultural and religious practices make it taboo to talk openly about ARSHR topics, which attributes the deterrent effect to adolescents seeking and utilizing SRHR services.[47–53] Similarly, social and religious norms were identified as barriers to accessing SRHR services in the Lao People's Democratic Republic, which is outside SSA.[21] These findings suggest that the SRHR services currently provided are not aligned with the sociocultural and religious norms of the community.[41] These findings signify the importance of identifying the existing cultural and religious norms regarding ASRHR services in the community. Additionally, community members and religious leaders should be engaged in planning and implementing adolescent SRHR programs.

One of the most important institutional challenges for accessing SRHR is the unfavorable attitude of healthcare providers. Various studies have indicated that young people do not access and utilize SRHR services mainly because of the judgmental and unfriendly attitudes of SRH service providers.[19,51,53–57] This negative attitude of the providers might be connected to their own cultural values and religious beliefs, which could result in denial of SRH services for adolescents.[58] The provision of quality healthcare services to adolescents should be equitable and nondiscriminatory based on the global standards established by the WHO.[59] Thus, healthcare providers should be culturally sensitive and practice a nondiscriminatory attitude of respect for all adolescents, regardless of their age or other factors.

The present study revealed a shortage of adequately trained staff and excessive workload, contributing to insufficient staffing, which affects access to ASRHR services. This claim has been substantiated in other studies.[44,55,60,61] Healthcare providers with heavy workloads are not in a position to provide appropriate counseling and information regarding SRHR.[62] To address this, it is important to train all healthcare providers in ASRHR and expand their numbers nationwide to ensure consistent service quality.

Additionally, one of the key suggestions of the participants was to expand the number of SRHR service providers by implementing task shifting through telemedicine or online platforms to enhance accessibility. The widespread use of mobile phones among adolescents may provide a great opportunity for virtual consultations, thereby enhancing access to SRHR service access.[43] A systematic review revealed that mobile applications for SRH enable the rapid, accessible, and cost-efficient delivery of health information in a user friendly manner.[63] Therefore, policymakers should consider adopting these approaches to ensure universal access to SRHR services and information among adolescents. Furthermore, study participants suggested that young healthcare providers should provide ASRHR services. It is evident that the age of healthcare providers could be a barrier to accessing SRHR services. A recent study conducted in Kenya reported that adolescents did not feel free to seek SRH information when served by elderly healthcare providers.[64]

The study further, under the institutional level factors, identified that unsupportive environments or inadequate infrastructure with open area in the health facilities where everyone can see is attributed preventing adolescents from accessing the SRHR services. These findings corroborate those of similar studies.[19,54] This could compromise the privacy

of adolescents, as others become aware of their personal issues. This could be addressed by constructing separate consultation rooms or by providing other options such as telehealth online consultations.[55]

Moreover, the long traveling distance between nearby health facilities and homes hinders access to and utilization of SRHR services, particularly in rural areas. Similarly, other qualitative studies indicated that physical inaccessibility to SRHR services was a challenge hindering adolescents from reaching the facilities.[18,21,40,41,51] This finding suggests that health facilities with youth-friendly centers should be enhanced to improve the accessibility of SRHR services for adolescents.

At the policy level, parental consent requirements for SRHR services were mentioned as a key challenge for adolescents, hindering access and utilization of the services. This finding is consistent with results from other studies, which have highlighted that adolescents, particularly those under the age of 15, often face significant barriers in accessing SRHR services without obtaining parental consent.[18,56,61,65] This limitation may not only limit their autonomy but also pose a challenge to timely and confidential access to essential SRHR services, thereby increasing their vulnerability to negative SRH outcomes. In Rwanda, a new draft bill was approved by the parliament's lower chamber towards the end of 2024, allowing individuals aged 15 years and above to independently access SRH information and services. The bill will now proceed to the appropriate parliamentary committee for further review before it is enacted.

Limitations

While we included a mix of various groups of participants (adolescents aged 12–19 years, healthcare providers, and various health stakeholders involved in ASRHR program implementation), parents of adolescents were not included. There could be a possibility of social desirability bias because the study focused on a sensitive issue, which might have led participants to either under-report or over-report information. Another limitation is that the audio recordings, which were transcribed in the local Kinyarwanda language and then translated into English, were not back translated into Kinyarwanda. Nevertheless, all were translated by experienced researchers fluent in both the local language and English.

Conclusion

This study showed that adolescents continue to face various interrelated challenges in accessing SRHR services and information across different levels of the socio-ecological framework. Therefore, multifaceted interventions are needed to enhance access to and utilization of SRHR services among adolescents. At an individual level, we recommend strengthening adolescents' self-esteem, self-efficacy, assertiveness, and confidence in making informed decisions. At the interpersonal level, interventions are needed to promote parent-adolescent communication about sexuality and parental empowerment to equip them with SRHR information. Community-based awareness campaigns and engagement in the planning and implementation of ASRHR programmes are recommended at the community level. At the institutional level, recommendations include making SRHR services more accessible by increasing service providers; offering specialized/refresher training; utilizing mobile and online platforms; establishing adolescent-friendly clinics; and ensuring a conducive environment for SRHR services. At the policy level, parental consent to access the ASRHR services should be waived as suggested by World Health Organization recommendation to revise adolescent SRHR laws, allowing young adolescents to access SRHR services without requiring parental consent. In addition, quantitative studies are important to quantify the role of each of the factors discussed in hindering access to SRHR services among adolescents.

Data Sharing Statement

Data used in this study are available from the corresponding authors upon request.

Ethics Approval and Consent to Participate

Ethical approval for this study was obtained from the University of Rwanda College of Medicine and Health Sciences Institutional Review Board (251/CMHS IRB/2023). Permission was also sought and granted by national and district-level administrations and organizations. Written consent was obtained from all key informants. In addition, consent and assent were sought from the legal guardians and adolescents aged < 18 years, respectively.

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Disclosure

The authors declare that they have no conflicts of interest in this work.

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