Enabel's Health Sector – Rwanda

BARAME PROJECT

Knowledge, Attitudes and Practices Study on Adolescents' Sexual and Reproductive Health

An Assessment in Seven Districts of Rwanda

Summary

Republic of Rwanda
Ministry of Health

RWANDA BIOMEDICAL CENTER
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Summary

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Key messages

1. Only 5% of respondents have ever visited a Youth-friendly Center
2. The main sources of information on SRH for the respondents were school teachers (66%), mothers (36%), friends (30%) and radio (15%); when the YFC was mentioned by only 2%
3. 69% of respondents from 15 to 24 were aware of contraception and among them 96% know where to get contraceptives
4. 88% of respondents know of Sexually Transmitted Infections (STI) and HIV
5. 89% of respondents agreed that a woman can get pregnant on the very first time that she has sexual intercourse
6. 65% of respondents said that the most suitable contraceptive for youths is condoms and only 12% said that it is the contraceptive pill
7. 89% of respondents think it is important to have sex protection
8. The adolescents feel more comfortable to discuss sex and reproductive health related matters with their mothers
9. 11% of respondents had engaged in sexual activity by the time of data collection
10. The majority of respondents having engaged in sexual activity have started between 16 and 20 years with 71%, 17% before 16 and 12% after 20
11. Among those who have experienced sexual intercourse, 26% did not consent to engage into sexual intercourse
12. 55% of the respondents who have engaged in sexual activity reported to have used condoms
13. Out of females who have had sex, 36% became pregnant with a mean age at first pregnancy of 17.9 years, while the minimum age was 15 years
14. The main barriers of access to SRH services and information were distance to the health facility, to the Youth-Friendly Services, negative social cultural influences, lack of privacy and confidentiality, and incomplete health package.

1. Introduction

This booklet presents a summary of the results of *"Knowledge, Attitudes and Practices study on Adolescents' Sexual and Reproductive Health services in Seven Districts in Rwanda to strengthen the Youth-Friendly Centre services".*

The study was commissioned by Society for Family Health (SFH) and conducted by AFRIHOPE, with technical and financial support of Enabel (Belgian development agency) through its Barame Project and Rwanda Biomedical Center through its Maternal Child and Community Health (MCCH) Division.

The data collection took place in September – October 2021 in the seven districts of Barame's intervention: Gakenke, Gisagara, Karongi, Nyamasheke, Nyarugenge, Rulindo and Rusizi.

2. Background and objectives of the study

The Government of Rwanda has made efforts to improve Sexual and Reproductive Health (SRH) of adolescents and youths through the adoption of various policies and strategies to ensure an access to affordable and equitable services.

Especially, investments were made in youth corners (YCs) in every health centre (HC) and in youth-friendly centers (YFC) in every district, both providing different services to accommodate amongst others, SRH needs of adolescents. However, the country continues to face several pressing challenges related to adolescent sexual and reproductive health (ASRH), including :

- Early onset of sexual intercourse,
- Teenage pregnancy,
- Unsafe abortion,
- Having risky sex,
- And low levels of contraceptive use.

Young people also have limited opportunities to learn about and openly discuss issues of puberty, sexuality, and family planning - a consequence of the social stigma, cultural and religious barriers surrounding these issues.

In that context, SFH was granted by Enabel to strengthen the eight YFC centers in the seven districts of Barame project's intervention with the objective to provide information and high-quality services on adolescent sexual and reproductive health, on drug and substance abuse and on gender-based violence and health friendly services.

The activities are implemented in partnership with Rwanda Biomedical Center (RBC) through its Maternal Child and Community Health (MCCH) Division and the Ministry of Youth and Culture (MYCulture).

To develop evidence-based strategies and better targeted interventions, Barame project and MCCH division requested SFH to commission this study to determine the knowledge, attitude and practices of young people about the sexual reproductive health, GBV and reveal potential barriers to behavior change.

The specific objectives being:

- Assess the knowledge, attitude, and practice of adolescent and young people (10-24) in relation to their Sexual and Reproductive Health
- Identify attitudes, practices, and beliefs of health care providers regarding provision of Adolescent & Sexual and Reproductive Health (ASRH) services at health centre and community level
- Identify knowledge gaps, cultural beliefs or behavioral patterns and practices of the community that create barriers to ASRH practices
- Assess the determinants of SRH among young people of 10-24
- Provide general recommendations based on the main findings of the study.

3. Methods

A cross-sectional study using mixed quantitative and qualitative methods was used. Quantitative data were collected from sampling of young aged 10-24 with structured questionnaires.

Qualitative data were collected through Focus Group Discussions (FGDs) with youths and conducted by age groups and through Key Informants Interviews (KIIs) conducted both at community and health center.

For the quantitative study :

For the cross-sectional quantitative study, 718 adolescents and young adults aged between 10 and 24 years old from the seven districts were selected, assuring the required optimum size and assuring representativity by age category: 10-14; 15-19; 20-24. They were interviewed with a structured questionnaire that includes socio-demographic information and set of questions (variables) to evaluate:

- Knowledge: on Family Planning (FP), HIV/AIDS and other Sexually Transmitted Infections (STIs), Gender-Based Violence (GBV) and pregnancy prevention
- Attitude: on getting SRH information and safe sex, comfort discussing SRH, and condom use
- Practice: on perception about YFC, source of information on ASRH, sexual activity, use of condoms and pregnancy outcomes.

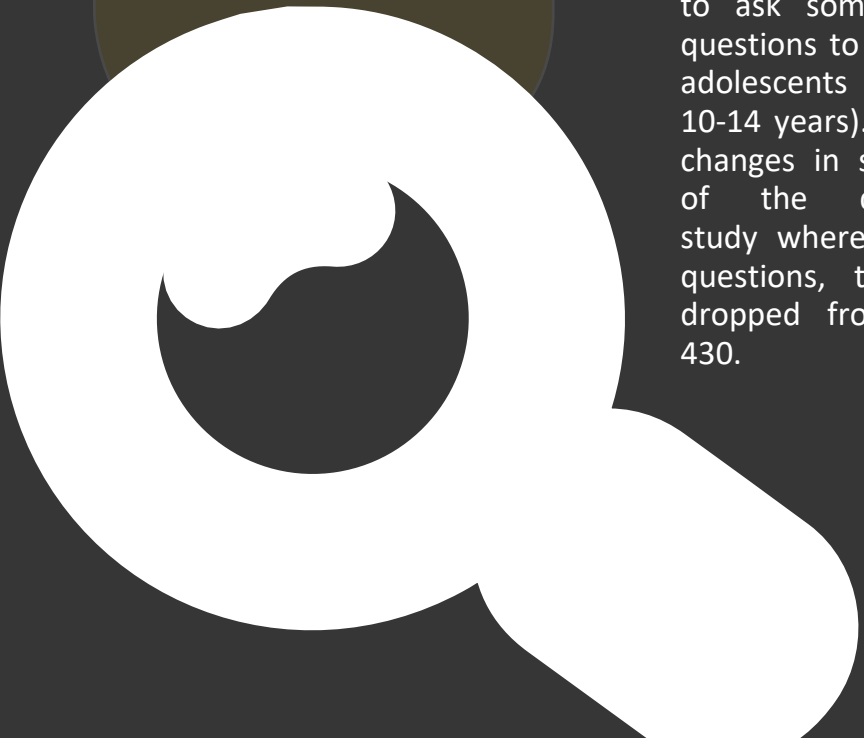
For the qualitative study design :

The assessment looked at the attitudes and practices of health care providers and community regarding provision of ASRH services and to the knowledge gaps and attitudes of the community in regard to ASRH services through:

- 49 Key Informants Interviews (KIIs) with representative from RBC, MYCulture, Barame team, Health Care Providers, Community Health Workers (CHW), Vice-Mayors in charge of Social Affairs, school teachers and National Youth Council representatives
- 36 parents and 244 youths were included in 56 FGDs conducted by age groups (10-14; 15-19 and 20-24)

All KIIs and FGDs were audio-recorded and transcripted.

Then, a codebook, which framed the key themes from the qualitative data was developed.



Important remarks on the methods

- Since convenience sampling was used to select participants, caution should be used in generalizing the results and conclusions of the study
- Rwanda National Ethics Committee recommended not to ask some sensitive questions to very young adolescents (category 10-14 years). This made changes in sample size of the quantitative study where, for some questions, the sample dropped from 718 to 430.

4. Study results: quantitative study

4.1. Sample size description

Table 1: **Respondents' socio-demographic description (n = 718)**

Variables	n	%		n	%
Districts			**Marital status**		
Gakenke	95	13,2%	Single	696	96,9%
Gisagara	90	12,5%	Married	14	1,9%
Karongi	105	14,6%	Divorced	1	0,1%
Nyamasheke	129	18,0%	Cohabitation	7	1,0%
Nyarugenge	80	11,1%	School attendance		
Rulindo	82	11,4%	At school	489	68,1%
Rusizi	137	19,1%	Completed	39	5,4%
Age			Dropped out	175	24,4%
10-14	288	40,1%	Never attended	15	2,1%
15-19	240	33,4%	Current enrolment level		
20-24	190	26,5%	Primary	288	58,9%
Gender			Secondary	196	40,1%
Male	332	46,2%	TVET	3	0,6%
Female	386	53,8%	IPRC	1	0,2%
Social category (Ubudehe classification)			University	1	0,2%
Category 1	167	23,3%	Family characteristics		
Category 2	234	32,6%	Only mother alive	104	14,5%
Category 3	315	43,9%	Only father alive	19	2,6%
Category 4	2	0,3%	Both parents alive	571	79,5%
			Orphan	**24**	**3,3%**

4.2. Knowledge variables

The level of knowledge of participants was assessed by the percentage (%) of correct answers to the questions asked to them.

4.2.1. Family Planning

69% of respondents aged from 15 to 24 were aware of contraception and among them, 96% know where to get contraceptives and mentioned the three most used methods: injections was given in 81% , pills in 76% and condoms in 51%, then implants were mentioned by 44%, vasectomy by 15%, periodic abstinence by 13%, tubal ligation by 12%, emergency contraceptive pills by 11% and finally, withdrawal during intercourse was the least mentioned method with 2%.

The knowledge was more prevalent for age category 20-25 (OR = 2,0 IC95% 1.3-3,1) and for female respondents (OR = 1,8 IC95% 1,2-2,8). 97% of respondents mentioned the health facilities as the source of FP services when the CHW were mentioned by 30% of respondents, the pharmacy by 25%.

Social category 2 (OR 1.9) and 3 (OR 2.5) have also a significant higher knowledge compared to category 1. There is no significant difference with school history or family characteristics.

4.2.2. HIV/AIDS and other Sexually Transmitted Infections

88% of respondents know the Sexually Transmitted Infections (STIs) and HIV infection and there is no difference between sex. The age category 15 – 19 have a significant better knowledge (57%) than 20 - 24 (43%), OR=3.7 (95% C.I.: 1.8-7.7).

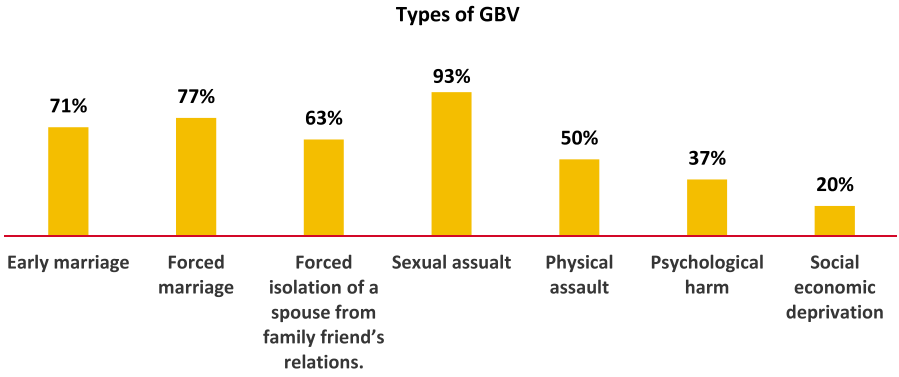
Furthermore, the level of school enrolment was also statistically significant where respondents in secondary school have more knowledge (OR=3.3, 95% C.I.: 1.4-5,0) than the ones in primary school.

Other variables such as marital status, gender and either having attended school or not, did not show any significant differences.

4.2.3. Gender-Based Violence

Respondents were asked which elements of the list constitute a GBV act and findings revealed that the majority of them know at least one type of GBV as it is illustrated in the Figure 1. Sexual assault is commonly known while social economic deprivation and psychological violence is less known.

Figure 1: Level of knowledge on different GBV act (%)



4.2.4. Pregnancy prevention

To assess the knowledge regarding avoiding unintended pregnancy, the youths were asked to agree/disagree with the following proposal: A woman can get pregnant on the very first time that she has sexual intercourse. 89% agreed with the statement, 4% disagreed and 7% did not know.

Other questions and results are illustrated in Table 2.

Table 2: Knowledge of respondents about pregnancy prevention

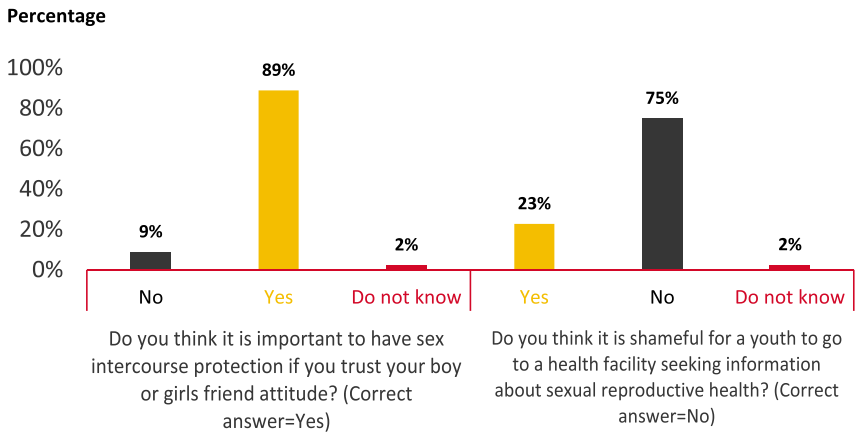
Variables (n= 430)	Frequency	%
Best time when a woman can get pregnant		
Before her first menstruation	22	5.1%
Halfway her menstrual cycle	135	31.4%
Any day of her menstrual cycle	67	15.6%
During ovulation	189	44.0%
Do not know	17	4.0%
A secondary school boy can make a girl pregnant		
Yes	242	56.3%
No	165	38.4%
Do not know	23	5.3%
Most suitable contraceptive methods for unmarried youths		
Pill	37	12.4%
Injection	47	15.8%
Condom	240	64.8%
Emergency contraceptive pills	19	6.4%
Withdrawal	2	0.7%
Periodic abstinence	178	26.2%
Implant	17	5.7%

4.3. Attitude variables

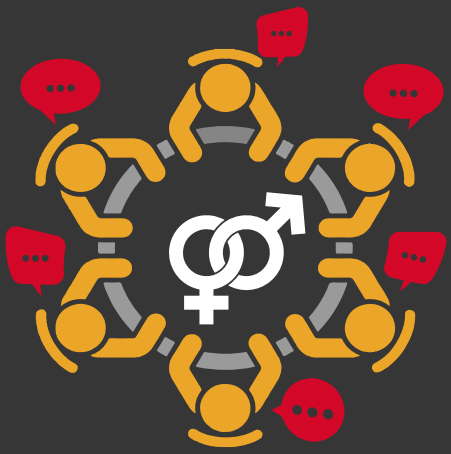
4.3.1. Looking for sexual health information and for safe sex

When asked about safe sex with a trusted friend and concerning the right to get adequate information, most respondents correctly answered the question with 89% and 75% respectively as illustrated at Figure 2. Female respondents (92%) have correctly responded to the question about safe sex more than male respondents (86%) but the difference was not statistically significant.

Figure 2: Level of knowledge on getting SRH information and about safe sex (%)



4.3.2. Comfort discussing Sexual and Reproductive Health with parents



For the comfort discussion on SRH with their fathers, 16% of respondents found it very easy, 49% found it easy or somehow, 28% found it difficult or very difficult and 7% found it impossible; but when they were asked about the frequency of such discussions, 57% answered “never”.

For the comfort discussion on SRH with their mothers, 25% of respondents found it very easy, 59% found it easy or somehow, 14% found it difficult or very difficult and 2% found it impossible; when they were asked about the frequency of such discussions, 31% answered “never”.

Adolescents feel more comfortable to discuss sex and reproductive health-related matters with their mothers than with their fathers but one third never talked about SRH with their mother and almost two-thirds never with their fathers.

4.3.3. Attitude about use of condoms

Respondents were asked if they agree that a girl can suggest to her boyfriend to use a condom during sexual intercourse, 64% of them agreed, 25% disagreed and 10% did not have an opinion. The agreement was associated with higher age: 71% for 20-24 category compared to 60% for 15-19 category (p-value=0.019). The sex and other independent variables were not associated with the answer.

4.4. Practice variables

4.4.1. Use of Youth-Friendly Centers by adolescents

Only 5% of respondents have ever visited a Youth Friendly Centers (YFC). The main reasons for not visiting were:

- Did not know about the existence of such centers
- Not needed
- For health services they go to CHWs or to health centres

Among the only 34% who visited the YFC, the main reasons were:

- For health-friendly services (50%)
- For sport, leisure, promotion (41%)
- For youth mobilization (24%)
- Entrepreneurship, youth economic empowerment (18%)
- Vocational training services (12%)

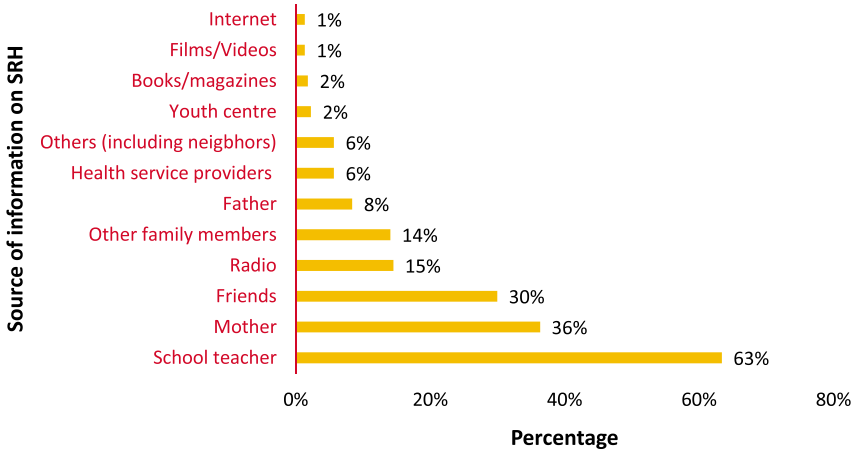
4.4.2. Source of information on Adolescent and Sexual Reproductive Health

61% of respondents said that have access to ASRH with difference between:

- Districts: Rulindo having the highest score with 77% ($p<0.0001$)
- Age category: highest score for 15-19 category with 73% ($p<0.0001$)
- Sex: highest score for female with 65% vs 57% for male ($p=0.023$)

The main sources of information for he respondents are illustrated at the Figure 3.

Figure 3: **Main sources of information on SRH reported by respondents in the study area**



4.5. Sexual activity among adolescents

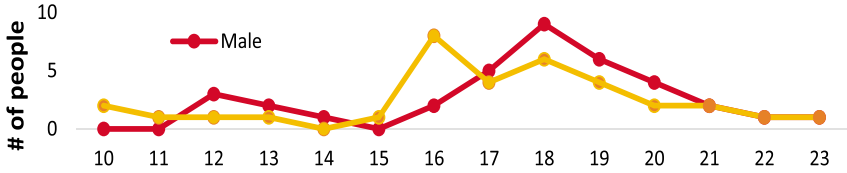
Respondents were asked a serie of questions to assess their sexual behaviours/practices.

Regardless of age and gender, the survey revealed that 11% of respondents had engaged in sexual activity by the time of data collection. Significant difference appeared logically between age groups: 3% for 10-14, 9% for 15-19 and 26% for 20-24 (p=0.001).

Another significant difference exists between the attendance of school: 5% for the one who attend and 29% for the out-of-school (p=0.001) and between districts: the majority of respondents who have had sex are from Nyarugenge with 29% (p=0.007), the lowest districts were Gisagara, Rulindo and Nyamasheke with respectively 4%, 5% & 7%; in between Karongi with 10%, Rusizi with 12% and Gakenke with 13%. The rate is 12% for male and 10% for female but the difference is not significant (p=0.440).

The majority of respondents having engaged in sexual activity have started between 16 and 20 years with 71%, 17% before 16 and 12% after 20. The highest proportion of sexually active adolescents had their first sexual activity at 18 years (21%). The youngest age was 10 for 2 female cases. When disaggregated by sex, it was found that female respondents had their first sexual intercourse earlier than their male counterparts as illustrated at Figure 4, but these differences are not statistically significant (p=0.555).

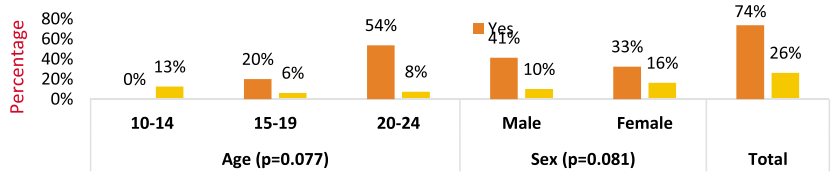
Figure 4: Distribution of sexual onset per sex



Age at fisrt sexual activity (n=80)

Figure 5 shows that among those who have experienced sexual intercourse, 26% did not consent to engage into sexual intercourse. Statistical analysis revealed no significant difference between sex (p=0.081) and age (p=0.077). Although there were no statistical differences (probably due to low numbers), the current results revealed that 41% of male adolescents consented to have sex, against 33% of female respondents.

Figure 5: Proportion of respondents who consented for sexual intercourse



Did you consent to have sex? (n=80)

4.6. Use of condoms

55% of the respondents who have engaged in sexual activity, reported to have used condoms while 31% indicated to never have used it and 14% refused to answer. Disaggregation by sex revealed among the users showed that 52% were male and 48% were female.

4.7. Pregnancy outcome

Out of 80 respondents who have had sex, 39 were female of which 14 (36%) became pregnant. The mean age at first pregnancy was 17.9 years, while the minimum age was 15 years.

At the time of data collection, 79% had live-births, while 7% had aborted and 14% were still pregnant. All respondents who got pregnant were single and were not enrolled at school.

5. Study results: qualitative study

5.1. Attitudes, practices and beliefs of health care providers on ASRH services

Findings from the KIIs with the Community Health Workers (CHWs) are:

- They serve youths who come to them requesting services related to SRH
- Girls are the ones who mostly look for services
- Few boys are coming for free condoms (main reason to come)
- Advisory services are also provided
- CHWs reported that they are comfortable discussing with adolescents on SRH, however, they reported that working from home is a challenge because their clients (youths) do not feel comfortable talking there

Findings from FGDs and KIIs with HCP reported that the main barriers of access to SRH services and information were distance to the health facility, negative social cultural influences, lack of privacy and confidentiality and incomplete health package delivered.

5.2. Knowledge gaps and attitudes of the community in regard to ASRH services

Findings from FGDs with parents revealed that they sometimes talk to their adolescents on some key topics; especially on how they should behave to avoid unintended pregnancies.

However, parents reported that they lacked information on ASRH, which is a key challenge for them to deliver appropriate messages to their children. Challenges faced by parents while discussing with their youths is the lack of mutual understanding caused by peer pressure groups, youths are not being open to their parents.

Nevertheless, they are motivated to discuss about sexual reproductive health and are providing these services using traditional methods.

However, some parents reported that they do not support the idea of discussing with their adolescents about sexual reproductive health. They believe that talking to their children about ASRH would stimulate their children to get engaged in premature sexual relationships with their peers.

Additionally, social stigma was reported as a barrier because adolescents did not want anyone they know, to see them at the CHWs' homes receiving SRH services due to association of ASRH services with sexual activities, which were sometimes labeled as "bad manners."

6. Conclusion and recommendations

Adolescence represents a critical window of opportunity when young people learn to make independent decisions and form their own attitudes and beliefs. Young people face a number of obstacles accessing sexual and reproductive health services.

These barriers relate to availability and accessibility as well as the quality of the services provided. The study revealed satifactory levels of Knowledge, Attitudes and Practices among interviewed adolescents, on the access to accurate SRH information, contraceptive methods, prevention and management of STIs, among others.

However, some concerns need special attention:

- Only 69% of respondents from 15 to 24 were aware of contraception ==> important room for improvement and among them 96% know where to get contraceptives
- 65% of respondents said that the most suitable contraceptive for youths is condoms and only 12% said that it is the contraceptive pills
- 11% of respondents had engaged in sexual activity by the time of data collection but with 3% for 10-14, 9% for 15-19 and 26% for 20-24)
- The majority of respondents having engaged in sexual activity have started between 16 and 20 years with 71%, 17% before 16 and 12% after 20
- Among those who have had sexual intercourse, 26% did not consent to engage into sexual intercourse
- Only 55% of the respondents who have engaged in sexual activity reported to have used condoms
- Out of the females who have had sex, 36% became pregnant, with a mean age at first pregnancy of 17.9 years, while the minimum age was 15 years
- The main barriers of access to SRH services and information were distance to the health facility, to the youth-friendly services, negative social and cultural influences, lack of privacy and confidentiality, and incomplete health package delivered.

6.1. Recommendations to the Youth-Friendly Centers (YFCs)

- Develop outreach strategies to attract more youths to come to YFC
- Develop attractive activities for youths to become entry point for further ASRH services and information

- Increase the mentorship programs and create Youth Mentor Forum (YMF) at each Youth-Friendly Centre to build youth innovation talents into development projects
- Establish "Youth Windows" at each Youth-friendly Centre that will work as a pathway window strategy for special case about adolescent reproductive health services
- Increase the number of technical staff at each YFC with experience on gender-based violence, SRH skills and drug abuse.

6.2. Recommendations to the health service providers

- Improve skills, knowledge, and capacity of CHW and give them all necessary guidelines and mentorship manuals related to support young adolescents because they are lacking ASRH reference documents and knowledge to deliver quality services
- Conduct awareness campaign about adolescent sexual reproductive health services, family planning and drug abuse offered at the YFC
- Conduct awareness of family planning and drug abuse not only in youth centres but also in schools and in the community
- Mobilize parents to participate in the family planning education campaigns.

6.3. Recommendations to the Government, and Development Partners

- Increase the number of YFCs in each district and decentralize them at sector level with a better collaboration with youth corners
- Improve technical capacities of parents to provide better guidance and information to their youths
- Strengthen Sexual Reproductive Health Education at primary school level
- Initiate a study on the high level of non-consented sex among adolescents (26.2%) as revealed in the current KAP study
- Conduct a specific study on the "Utilization of YFCs" to elucidate the current low attendance by adolescents
- Increase capacity building of ASRH service providers at all levels.

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