CONTRACEPTIVES AVAILABLE BUT NOT ACCESSIBLE

A need to prevent teenage pregnancies

Key messages

- Adolescent girls have limited access to modern contraceptive methods, leading to unintended pregnancies. Some girls resort to unsafe abortions which can result in illness and death.
- In Rwanda, 5% of girls start childbearing between the ages of 15 to 19. Fertility increases with age: while around 1% of 16-year-olds have a child, 13% of 19-year-olds have given birth (DHS 2020).
- Currently, girls under age 18 need parental consent to access contraceptives, which they do not always get. The draft Law regulating health services is expected to lower the age of majority to access all health care services to 16 (from 18), which would allow youths aged 16 and 17 to access modern contraceptives without parental consent. This is in line with WHO recommendations on family planning as well as the African Youth Charter, which obligates Rwanda as a signatory to provide access to youth-friendly reproductive health services, and specifically contraceptives.
- To complement this planned lowering of majority age, it is recommended to increase and improve sexual and reproductive health (SRH) services targeting adolescents through upgrading existing youth corners at health centers, strengthening the capacity of the health workforce on adolescent SRH, and reforming financing of such services.

Adolescent girls' limited access to contraceptives

Modern contraceptive methods, such as contraceptive pills and implants, intrauterine devices (IUDs, also known as coils), emergency contraceptives ("morning after pill") and male condoms are widely available in Rwanda. Nevertheless, there is a high unmet demand for contraceptives, especially among sexually active unmarried women and girls. While 14% of married women aged 15 to 49 have an unmet need for contraception, this number jumps to 37% for sexually active unmarried women aged 15-49 and to 59.1% for sexually active unmarried girls aged 15-19 (DHS 2019-20). Increasing the use of modern contraceptives would decrease the number of unintended pregnancies and subsequent unsafe abortions.

Teenage girls are particularly affected due to their age. While sex without threat or violence between adolescents aged 14 to 17 is not criminalized under Rwandan law (Art. 133, Law on offenses and penalties), minors may only access reproductive health care services, including contraceptives, with parental consent (Art. 7, Law relating to human reproductive health). This is also true for abortions, which are permitted for child pregnancies but require an application by their legal representatives (Art. 6, Ministerial Order on abortion conditions). Minors are not always able to obtain parental consent for contraceptives, emergency contraceptives or abortion

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care due to cultural and religious beliefs and stigma around sexuality, restricting the uptake of contraceptives among unmarried women and girls. Thus, unsafe abortion methods are their only choice if they want to end an unintended pregnancy and avoid its potential negative impact (such as dropping out of school, social stigma, parental blame or raising a child conceived through sexual violence). This situation violates minors' rights to reproductive health based on their age, in effect disregarding the right to non-discrimination enshrined in the Constitution (Art. 16) and the Law relating to human reproductive health (Art. 5).

The unmet need for contraceptives is compounded by the fact that 5% of girls aged 15 to 19 have begun childbearing (DHS 2019-20) and adolescents lack knowledge on sexual and reproductive (SRH) health. Making modern contraceptive services widely available to girls will not only have a positive impact on their health but also help them grow into women able to plan pregnancies to suit their needs.

A. Critical root causes

The main root cause of limited access to contraceptives for teenage girls is the legal requirement of parental consent. A lack of youth-friendly SRH services also contributes to the gap in accessing contraceptives.

B. Evidence on the low uptake by adolescents of sexual and reproductive health services offered by existing "youth corners"

Investments by the Government of Rwanda in adolescent sexual and reproductive health (ASRH) have resulted in 84% of health centers having a "youth corner" offering services such as: testing and treatment for sexually transmitted infections; menstrual health and hygiene; immunizations including the HPV vaccination; contraception and family planning; pregnancy testing; linkage to antenatal care and post-abortion care; and treatment for sexual violence (*Enabel, 2022a*). Almost all youth corners (99%) have an ASRH focal person, 89% a specific adolescent consultation room, and 25% a separate waiting room (*Enabel, 2022a*). However, the study by Enabel (2022a) showed that the youth corners' quality of service provision was lacking, with only 11% providing "good" ASRH services, while 82% were "acceptable" and 6% "insufficient." In addition, the study found that 67% of health care providers are not aware of relevant guidelines and standard operating procedures on providing services to youths.

The same study found that only 4% of the interviewed adolescents and young people (ages 10-24) had visited any youth corner for ASRH services during the 12 months preceding COVID-19, while 42% received information, counseling or health services in schools, clubs, and community meetings and 29% by participating in community health education sessions. Nevertheless, 93% of adolescents know that they can seek medical advice at youth corners should they become pregnant.

The main barriers to accessing ASRH services at youth corners were fear of stigma or discrimination; lack of a youth-friendly service space guaranteeing confidentiality; poor parent involvement; long waiting times; inconvenient opening times of youth corners; and lack of dedicated ASRH staff.

C. Evidence on reproductive and sexual health and knowledge in Rwanda

Teenage girls, especially in early adolescence, are susceptible to significant negative health consequences of pregnancy and delivery as their bodies may not be physically ready. In girls aged 15 to 19 globally, maternal conditions are among the four top causes of loss of disability-adjusted life years (DALYs) and second top cause of death (*UNICEF, 2022*). Adolescent pregnancies are also a significant reason for not completing secondary school (*Ministry of Health, 2019*).

Only 10.2% of Rwandan girls aged 15 to 19 know when they are fertile during their menstrual cycle (DHS 2019-20). Fertility among girls aged 10 to 19 overall is 2.6%. Fertility is very low before age 16 but increases from age 16: about 1% of 16-year-olds have given birth, while 13% of 19-year-olds have given birth (National Institute for Statistics, 2022). Among girls aged 15 to 19, 5% (37,959 girls)[1] have begun childbearing, 4% have given birth, and 1% are pregnant with their first child (DHS 2019-20).

The study by Enabel (2022a) showed that 90% of young people aged 10-24 knew about condom use, 74% could name at least one contraceptive method, and 75% said they could obtain one if necessary. However, only 21% of adolescents were aware that they could take an emergency contraceptive to stop a pregnancy from happening. Another Enabel study (2022b) found that 89% of youths believe that contraception is important, 65% thought that the most suitable contraceptive for young people are condoms and 12% that it is the contraceptive pill. A total of 11% of interviewed youths had started engaging in sexual activity, of which 71% started between 16 and 20 years of age and 55% had used condoms; among girls, 36% became pregnant with a mean age of first pregnancy of 17.9 years and a minimum age of 15 years. A fourth (26%) of those interviewed who had started sexual activity had done so without consenting to intercourse.

[1] As per the national census 2022, 759,178 girls were aged 15 to 19.

Young people obtain information on sexual and reproductive health mainly from school teachers (66%), mothers (36%), friends (30%) and the radio (15%); 84% of interviewed youths found it easy or very easy to discuss SRH with their mothers (*Enabel, 2022b*). Parents are motivated to discuss SRH with their children but lack information to deliver appropriate key messages (*Enabel, 2022b*).

Rwandans overwhelmingly get their modern contraceptives through the public sector, which provides 93% of modern contraceptives; the private sector provides 6% (DHS 2019-20) and social marketing and pharmacies provides 1%. The number of adolescent girls using contraceptives or wanting to use contraceptives but not receiving parental consent has not been studied.

It is unknown how many of the estimated 60,000 illegal abortions per year (*Guttmacher, 2013*) are due to teen pregnancies, and how many adolescents experience abortion complications. But it is known that abortion complications account for 10.7 cases per 1,000 women aged 15 to 44 (*Basinga et al., 2012*), and unsafe abortions continue to contribute to maternal mortality, with an estimated 7.14% of total maternal deaths in public hospitals being abortion-related (*Rwanda Biomedical Centre, 2022*). Treating complications of unsafe abortions cost the Rwandan health system US$1.7M in 2012[2], and 49% of these costs were non-medical (overhead and infrastructure) (*Vlassoff et al., 2015*). Lastly, 18% of the female prison population in Rwanda are girls aged 15-19, incarcerated for illegal abortions (*HDI, 2019*).

Possible Solutions

The most impactful way to increase adolescents' access to modern contraceptives is through lowering the age at which they can access healthcare without parental consent, including ASRH services specifically, as foreseen in the draft Law regulating health services, to 16 (from age 18).[3] This would also be in line with the African Youth Charter, signed by Rwanda in 2007, whose Article 16(2)(c) obligates state parties to provide access to youth-friendly reproductive health services, and specifically contraceptives. This would also move Rwandan regulation of family planning in the direction of the WHO family planning guidelines which recommend that contraception should be available and accessible to adolescents from 15 years on, without requiring parental authorization by law, policy or practice (WHO, 2022). In addition, the following solutions are available:

- All health workers could be trained on ASRH and on how to provide youth-friendly services to mainstream adolescent-friendly health services throughout the health care system; while this would be the best-practice approach, it might only be possible to finance up-to-date ASRH training for ASRH focal persons in existing youth corners.
- Existing youth corners could be improved to provide higher-quality services and facilities, confidentiality, and better community outreach.
- ASRH focal persons could be required to undergo values clarification and attitudes transformation training.
- In the mid-to-long term, ASRH services could be integrated into the national performance-based financing (PBF) scheme[4].
- Government could monitor the number of health care providers trained in ASRH provision.
- Community-based monitoring and evaluation by youth groups of ASRH services could be implemented to assess changes in quality of ASRH services over time.
- Research could be better funded and increased on the pregnancy and abortion rate among teenagers, unmet need for contraceptives in adolescents, and source of information on SRH used by adolescents to allow monitoring and better targeting of policies and interventions.
- Adolescents' knowledge of and demand for contraceptives could be increased through advocacy, media and community outreach targeting adolescents, parents and health care providers.

Research has shown that building stand-alone youth centers, or creating them within existing health infrastructure, is not only expensive but also less effective for the uptake of ASRH services. Mainstreaming adolescent-friendly health services throughout the health care system is effective and considered global best practice (*Chandra-Mouli et al., 2015*). Consequently, this brief does not recommend increasing the number of youth corners in areas of Rwanda with lower coverage of them.

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[2] Given the current inflation rate in Rwanda, US$1.7M was estimated to US$2.72M in 2022.

[3] Lowering the age at which parental consent is not necessary even further for ASRH specifically (e.g., to age 14) is politically not feasible. Practically, it is not necessary due to the very low fertility rate of adolescents below age 16.

[4] "PBF refers to the transfer of money or material goods to health facilities and providers after predefined results have been achieved such as health services that meet protocols and standards. The incentives are received at regular intervals based upon verified results." For more information on Rwanda's PBF scheme, see the Performance Based Financing Procedures Manual for Health Facilities (2021) by the Rwandan Ministry of Health, available at https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Guidelines_Protocols/PBF_Procedures_Manual_for_HFs____February_2021.pdf.

Recommendation

It is recommended that the Ministry of Health accompanies the planned policy change of lowering the age to access health care without parental consent to 16 with the following policy measures to facilitate uptake of ASRH services by teenagers:

- Training on ASRH and on how to provide youth-friendly services should be incorporated into all pre- and in-service trainings for all health workers and made available as refresher training for continuing medical education (CME) credits to mainstream adolescent-friendly health services.
- Existing youth corners should be improved for both female and male adolescents by:
  - mandating the presence of a permanent health care practitioner trained in ASRH, adolescents' rights and confidentiality;
  - requiring and providing regular, up-to-date ASRH trainings to ASRH focal points;
  - ensuring all ASRH services are provided free of charge to teenagers;
  - requiring ASRH focal points to undergo values clarification and transformation training;
  - disseminating widely all relevant laws, policies, guidelines and standard operating procedures among health workers;
  - improving the infrastructure of youth corners (separate waiting and consultation rooms for adolescents) to make them friendlier spaces;
  - improving access to youth corners through convenient opening hours for adolescents;
  - improving information on youth corners within the health center premises (e.g., signposts with adolescents' rights, focal persons' contact details; opening hours and services offered) and using targeted community outreach at schools;
  - reaching out and providing ASRH information to parents, particularly mothers, and through collaboration with community organizations and NGOs.
- ASRH services should be integrated into the performance-based financing (PBF) scheme; and
- Research on ASRH and monitoring of ASRH services should be increased.

A. Impact

Lowering to 16 the age at which health care services can be accessed without parental consent would remove the main barrier to accessing modern contraceptives and other ASRH services as adolescents would not need to overcome potential stigma and parental dissent.

Elevating existing youth corners by specifically addressing access barriers identified by adolescents would help to ensure that they respond better to their needs and would, therefore, be used more frequently. Training health care providers in ASRH instead of building new youth corners is an economical way to encourage teenagers to perceive health care services as "friendly" and more desirable to seek out; any contact with the health care system could then be used as an opportunity for education on ASRH. Bringing ASRH services to the community with targeted outreach, e.g., to places typically frequented by youth, is also an economical way to reach more teenagers.

Including ASRH services in the PBF scheme would incentivize health care facilities to improve the quantity and quality of ASRH services in youth corners and work with ASRH specialists. Expressly including ASRH in the services provided by youth corners and the presence of specially trained health care providers would make ASRH, and specifically appropriate youth-focused contraceptive services, more accessible to adolescents and their parents. Combined with research and advocacy on ASRH, these measures would increase knowledge of young people and their parents, counter misinformation, and destigmatize sexual and reproductive health in health care settings. Over time, it would increase the number of adolescents using modern contraceptives and thus avoid unintended pregnancies.

Adolescence is a critical window of opportunity during which youths form their own attitudes and beliefs which can be harnessed to educate them on SRH. Well-informed teenagers grow into women (and men) with adequate knowledge on family planning, able to delay, space and prevent pregnancies to suit their needs. Consequently, the recommendations would in the long-term lead to a lower rate of unintended pregnancies and thus a decrease in unsafe abortions, health care costs and poverty

B. Feasibility

Even though the age of majority to access health care is already planned to be lowered to 16, making contraceptives more widely available to adolescents is a culturally sensitive topic in Rwanda. Relevant stakeholders, such as parents, teachers, health care providers, faith-based organizations, churches and religious leaders may be opposed to making ASRH

services, and specifically contraceptives, more widely and easily available to teenagers due to the stigma and sensitivity around sexual activity of unmarried youths and young adults. Opposition based on societal and religious norms does not override the compelling reasons for the necessary policy change to avoid unintended pregnancies and their negative impact on teenagers. Therefore, any policy change would need to be accompanied by targeted advocacy as well as strategic communication efforts to generate buy-in from society, such as advocacy at all levels (government, civil society, religious organizations, and health care providers), social mobilization, and enhanced collaboration with and outreach to faith-based organizations and churches. Capacity strengthening with health care providers would also be needed to increase understanding of the importance of access to contraceptives for those who are sexually active and the potentially severe consequences of an unintended pregnancy for a patient. In addition, knowledge of and demand for contraceptives from teenagers and their parents would need to be increased through media efforts; targeted, continuous community outreach; and comprehensive sexuality education.

The additional budget needed may initially deter some policymakers, but it can be shown that investments in contraceptives are outweighed by medical and societal costs saved. The recommended policy actions would in the long term save costs by reducing unintended pregnancies and resulting unsafe abortions, health care costs, and poverty.

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Operationally, challenges are the general shortage of staff and staff turnover. The recommendations require additional space, staff and training to be implemented as well as an update of financing processes for ASRH services. This requires additional budget which may not be available and could lead to a delay in service delivery if existing health care workers are used for ASRH services instead of other health care services. However, there is a plan to increase the number of health posts to 1,000 and integrating ASRH provision as a standard for health care providers could be included in the plan.

Studies to further understand the knowledge, attitudes and behaviors of adolescents around sexual and reproductive health are feasible, provided expertise and adequate resources are made available.

Solutions related to the inclusion of ASRH products and services in the national PBF scheme are complex and resource-intensive, and yet feasible. It would require long-term engagement with government agencies outside the Ministry of Health, including the Rwanda Social Security Board, the Ministry of Finance and Economic Planning, development partners and health facilities themselves.

C. Cost considerations

Costs can be considered from several perspectives. From a health systems perspective, investments in family planning are cost-effective. A business case on family planning (*Ministry of Health, 2019*) showed that if Rwanda achieves a modern contraceptive prevalence rate of 70% amongst women and girls by 2050, every US$1 invested in family planning will yield around US$402 of benefits (or savings) in health, education, economy, agriculture and infrastructure, which can be used to finance other development activities. By 2050, it would: lift more than 2.5 million Rwandans out of poverty; reduce moderate to severe food insecurity to 7.8% (from 20% in 2015), significantly reducing food subsidies provided by the Government of Rwanda; lower the prevalence of child labor to 10.2% (from 13% in 2015); and improve school completion rates.

To determine costs for the suggested complementary policy actions (improve youth corners, train the workforce, include ASRH in the PBF scheme, and more research on ASRH), a cost inventory and analysis must be conducted. This will enable policymakers to understand the resources needed to: upgrade health center infrastructure to improve youth corners; increase the number of ASRH staff and extend opening hours; provide ASRH training to the health workforce; provide training on data collection to youth corner staff to increase monitoring; increase research activities; and fund ASRH services through their inclusion in the PBF scheme. Costing would also need to consider any

money saved by reducing the total number of abortions and cases of post-abortion care resulting from clandestine (and usually unsafe) abortions.

A societal view would need to consider the economic cost to society of adolescent pregnancies (e.g., reduced lifetime income due to early pregnancy and resulting impact such as dropping out of school and lower or no work income) and associated mortality and morbidity. It would need to investigate the association between increased access to contraceptives and decreased unintended teen pregnancies and associated mortality and morbidity.

From an individual (pregnant adolescent) perspective, increasing access to contraceptives would likely increase lifetime income because women who have children later are able to finish school and find work. Better access would reduce out-of-pocket costs resulting from unintended pregnancies. Women currently pay about US$15-30 for a safe abortion covered by community-based health insurance (CBHI) but around US$30-70 if they access a public hospital without a transfer note or use Isange One Stop Center first. At a private clinic, women pay US$100-300 for an abortion; using (mostly ineffective) traditional medicine costs US$10-30; and abortion pills such as mifepristone cost US$10-20. Additional costs may include US$5-10 for transport and US$2-5 for materials. Furthermore, unsafe abortions using traditional medicine, a self-bought abortion pill or other methods have higher risk of complications that may require post-abortion care. Due to stigma, women often prefer to access hospitals directly rather than obtaining a transfer from a health center, in which case they must pay the full cost of approximately US$100-300 (more if complications are severe) instead of US$10-30 if they first seek post-abortion care at a health center.

D. Policy pathway

The draft Law regulating health services in its current form (July 2023) plans to lower the age of majority to 16 years (Art. 3(24)) and to repeal the law relating to human reproductive health (Art. 174). The draft Law still needs to be adopted by Parliament.

The suggested improvements to youth corners and the integration of ASRH services into the performance-based financing scheme can be adopted through a ministerial instruction issued by the Ministry [5]of Health. Their implementation, as well as increased research on ASRH and monitoring of ASRH services, can be coordinated and facilitated by a technical committee established and led by the Ministry of Health.

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