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A qualitative study in Rwamagana District, Rwanda, on the acceptability and utilisation of sexual and reproductive services in youth corners

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Abstract

Background Teenage pregnancies remain a pressing issue in Sub-Saharan Africa, including Rwanda. Adolescent girls and young women (AGYW) continue to face a myriad of challenges in accessing sexual reproductive health (SRH) services. This study examines the accessibility and utilization of SRH services provided to AGYW in youth corners in Rwamagana district, Rwanda. It seeks to explore challenges and opportunities for accessing SRH services in youth corners.

Methods Utilising a descriptive qualitative research design, the study included 8 in-depth focus group discussions and 4 key informant interviews. Stratified sampling methodology was utilised to increase the representativeness of the AGYW and 71 AGYW participated in the study. The feminist standpoint theory aided in focusing on marginalised voices, analysing power structures and contextualising experiences of AGYW in Rwamagana. The socio-ecological model was used to analyse data using thematic analysis.

Results The findings reveal various SRH services accessed by AGYW in youth corners, including family planning, services regarding sexually transmitted infections (STIs) and menstrual hygiene management. Barriers to service utilisation included limited knowledge about the available services, distance to health facility, unavailability of some services, AGYW being viewed as a prostitute when one is seen with condoms, norms that discourage open discussions about sexual health, and stigma surrounding the use of contraceptives. This was further worsened by the gender norms which create additional hurdles for AGYW, as they navigate societal expectations and restrictions that are not equally imposed on their male counterparts. The inconsistent availability of services coupled with diverse operating schedules also posed a challenge to accessing services. Most AGYW expressed trust in the healthcare providers' ability to maintain confidentiality, given their training and professional obligations. This sense of trust acted as a motivating factor for AGYW to be more open and forthcoming in utilising the available SRH services.

Conclusion Addressing the identified challenges faced by AGYW in accessing SRH services in youth corners will help to promote their well-being and bodily autonomy.

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Plain English Summary

Adolescent girls and young women (AGYW) in many communities face challenges in accessing sexual and reproductive health (SRH) services, which are critical for their well-being and rights. This study examines the availability, accessibility, and acceptability of SRH services offered to AGYW in youth corners within the Rwamagana district, while identifying barriers and opportunities for improvement.

The research revealed that a variety of SRH services are available at youth corners, including family planning, menstrual hygiene management, and services regarding sexually transmitted infections (STIs). However, despite the availability of these services, many young women face barriers to accessing them. These barriers include a lack of knowledge about the available services, cultural norms that discourage open discussions about sexual health, and stigma surrounding the use of contraceptives.

The study highlights the need for greater awareness and education to encourage AGYW to seek sexual reproductive health services. It also calls for community involvement to reduce the cultural stigma and misconceptions surrounding SRH. By addressing these challenges, the accessibility and utilisation for young women can be improved, which in turn will promote their well-being and protect their reproductive rights. This will contribute to reducing teenage pregnancies and empowering AGYW to make informed decisions and choices about their sexual health.

Keywords Adolescent girls and young women, Youth corners, Sexual reproductive health, Acceptability, Utilisation

Introduction

Teenage pregnancies continue to be a challenge in sub-Saharan Africa because of limited access to sexual reproductive health (SRH) services including contraceptives. The World Health Organisation noted that sub-Saharan Africa has the highest prevalence of teenage pregnancy in the world, with 21% of adolescent girls accounting for new mothers [1]. Teenage pregnancy prevalence is as high as 29% in countries like Malawi, whilst in countries like Kenya it is lower at 18% [2]. Rwanda is not an exception to this phenomenon, as an estimated 21% of girls aged under 19 years become pregnant yearly [3]. Rutayisire et al.. posit that adolescents remain a neglected group in Rwanda's healthcare model, as they are considered to have a relatively low burden of disease [4]. This is, however, not the case, as the government has enacted laws and policies to promote adolescent sexual reproductive health (ASRH), such as the National School Health Policy and the National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan (2018–2024) [5].

These policies led to the creation of youth corners in health centres to promote access to SRH information and services for young people including adolescent girls and young women (AGYW). This has, however, not yielded the envisaged results, as Asiimwe stated that more than 25% of girls aged 15 to 19 years in Rwanda have their first sexual experience by the age of 15 years, and 15% of births occur in teenage mothers below the age of 20 years, which shows that there are gaps in accessing and utilising SRH services by AGYW [6]. According to the demographic and health survey (DHS) 2020, there has been a decline in knowledge levels among young women on HIV from 65% in 2015 to 59% in 2020, which contrasts with various initiatives that have been established to promote information dissemination on SRH and HIV for informed decision making [7].

According to Rutayisire et al., knowledge of SRH influences how one utilises reproductive health services; as such, without knowledge, young people continue to engage in risky behaviour and fail to access services in a timely manner [4]. Ndayishimiye et al. reported that adolescents' overall burden of disease is 23%, mainly due to unplanned teenage pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including HIV [8]. This is augmented by Rutayisire et al.., who further reported that 60% of all new HIV infections occur in adolescents [4]. Therefore, there is a need to invest in meeting the SRH needs of adolescents, who, according to the UNDP 2022, constitute 78% of Rwanda's population [9].

Moreover, Coast et al. posit that the unmet need for contraception has led to an increased number of unintended pregnancies [10]. The consequences of teenage pregnancy jeopardise the future of AGYW by trapping them in an intergenerational cycle of poverty. Ngerageze et al. argued that teenage pregnancy perpetuates the exclusion and marginalisation of young women, which is further worsened by the associated health risks, which include cervical cancer, obstetric fistula, maternal death, unsafe abortion, and HIV infection [11].

According to the Ministry of Health, the rate of adolescent pregnancies in Rwamagana district is considerably greater than the national rate, with an estimated 35% of girls between the ages of 15 and 19 becoming pregnant [12]. The report further states that only 45% of adolescent females in Rwamagana district have precise knowledge about family planning and that only 15% of them have used contemporary methods of family planning which include injectables, condoms and oral pills, suggesting

that there is a knowledge and accessibility gap. Ndayishimiye et al. suggested that a lack of comprehensive youth SRH services, skilled staff, an environment conducive for adolescents, a shortage of information on the services provided and none friendly provider attitudes hinder accessibility to SRH services [8]. In previous years, studies have been conducted to evaluate youth-friendly services, resource allocation, and SRH interventions. However, there is limited information available on the specific challenges and obstacles that AGYW in Rwamagana encounter when accessing SRH services from youth corners. This gap leaves important factors unexplored, such as the intersectionality of gender, location, economic status, religious beliefs, and societal norms, in influencing the acceptability and utilisation of SRH services. This study is informed by the feminist standpoint theory, which values the lived experiences of AGYW in understanding barriers to SRH services, and by the socio-ecological model, which provides a framework for examining how individual, interpersonal, community, and societal factors interact to influence SRH service acceptability and utilisation. In this study, acceptability refers to the extent to which AGYW perceive youth corners as safe, respectful, confidential, and responsive to their SRH needs. This study therefore aimed at assessing the acceptability and utilisation of youth corners by AGYW in Rwamagana District.

Methods

Study location

The study was conducted in 4 health centres in Rwamagana district in Rwanda's Eastern Province. These health facilities included the Rwamagana, Avega, Nyagasambu and Gahengeri health centres. The district consists of 474 villages, 82 cells, and 14 sectors. According to the EICV5 survey data, Rwamagana district had 489,000 residents in 2022. The population density is 455 people per km2, which is 9% greater than the 416 people per km2 national average. According to the survey, the majority of the population is young, with 53% under the age of 19 and 82% under the age of 40. Females make up 54% of the population [13]. The district has one provincial hospital and 14 health centres, and the study focused on 4 health centres with youth corners.

Study population

The study population consisted of AGYW aged 12–24 years residing in Rwamagana District, Rwanda. Both users and non-users of SRH services from youth corners were included to ensure diverse perspectives. Key informants included youth corner focal persons who could provide complementary insights on service delivery and accessibility.

Study design

This qualitative study employed a descriptive design, ideal for observing and describing participants' experiences, as recommended by Sandelowski [14]. Focus group discussions (FGDs) and key informant interviews (KIIs) were adopted in this study. FDGs allowed AGYW to express themselves freely and stimulate discussion, whereas key informant interviews provided insights from youth corner focal persons. Additionally, an observation checklist facilitated data collection on the services provided to AGYW in youth corners.

Sampling

The study used a stratified sampling methodology to promote increased representativeness of AGYW in Rwamagana district [14]. The 14 youth corners in Rwamagana district were grouped into subgroups based on factors such as the number of adolescent and young female residents and living in close proximity to Kigali, the capital city. From these subgroups, four youth corners were selected via purposive selection (maximum variation) to represent different perspectives and experiences [15]. The Rwamagana health centre (dense) and Avega health centre (sparse) were selected in the urban area, and the Gahengeri health centre (dense) and Nyagasambu health centre (sparse) were selected in the rural area. This selection was based on the premise that proximity to Kigali affects accessibility to SRH services, as some individuals seek these services in Kigali, and proximity to Kigali has a behavioural influence on the lifestyle of AGYW.

Participants were purposively identified from relevant AGYW subgroups to ensure representation of both service users and non-users. Eight FGDs with a total of 71 AGYW were conducted, four with AGYW who had used the services and four with those who had not. In addition, 4 KIIs were conducted, with the youth corner focal person from each of the four youth corners.

Youth corner focal persons were selected as key informants for the study to give an account of the services they offer at the youth corners, utilisation of the services and challenges encountered. These were trained health personnel on youth-friendly service provisions with more than a year of experience working in the youth corner. All the selected youth corners had at least one focal person who was responsible for ASRH.

Data collection tools

An FGD guide (see Additional file 1) with carefully crafted questions elicited detailed responses from AGYW, while KII questions were structured to gather insights from youth corner focal persons regarding SRH service provision. Additionally, an observation checklist based on the Youth Corner Standard Operating Procedure (SOP) facilitated structured observations of SRH

services and facility conditions. All tools were culturally adapted, translated into Kinyarwanda, and designed in alignment with the socioecological model and feminist standpoint theory, ensuring that individual experiences, interpersonal influences, community norms, and societal structures were explored.

Data procedures and management

Empower Rwanda facilitated engagement with health centres. Discussions and interviews were conducted in Kinyarwanda; the interviews lasted 45 min to 1 h 30 min and were recorded with consent. Covert participant observation was utilised for natural data collection. Data collection commenced on the 15th of May 2023 and ended on the 2nd of June 2023.

Audio recordings were transcribed verbatim and then translated to English. The data was de-identified.

Data analysis

This study employed the socioecological model to analyse data, exploring the factors influencing the acceptability and utilisation of SRH services by AGYW in the Rwamagana district. The model considers multiple layers of influence on individual behaviour, including individual, interpersonal, community, and societal factors [16]. Thematic analysis of the transcribed and translated data identified patterns and themes, facilitated by Dedoose software (version 9.0.107). The research team ensured data credibility and dependability through multiple readings, independent coding, and consensus discussions. A codebook was developed to maintain consistency in the coding process, organising codes into categories for pattern identification. For the observation checklist, both principal investigators independently applied coding criteria, compared results for agreement, and resolved discrepancies through consensus discussions. Emphasis was placed on recurring themes and patterns to ensure intercoder reliability.

Ethical considerations

Approval was sought and granted from the University of Global Health Equity's Institutional Review Board (IRB) and the Ministry of Health of Rwanda. For participants who were 18 years and above, consent was sought prior to their participation in the study. For those under 18 years, consent was sought from their parents or guardians after they were explained what the study was about. In addition, adolescents below the age of consent provided their assent to participate. This was done through explaining to the participants what the study was about and sharing with them consent forms that were translated into Kinyarwanda. To ensure privacy and confidentiality, the study participants were required to not include their personal identifiers, such as their registration numbers or national ID.

Table 1 Participants' demographics

Characteristics		FGDs	Percentage	KIIs
Sample size	FGDs + KIIs	71	100%	4
Age	14–18	31	44%	-
	19–24	40	56%	-
SRH services	Have used the services	34	47%	-
	Have not used the services	37	52%	-
Gender	Females	71	100%	1
	Males	0	0%	3
Location	Rwamagana	18	25.35%	1
	Avega	17	23.94%	1
	Nyagasambu	18	25.35%	1
	Gahengeri	18	25.35%	1

Participants' demographics, including sample size, age range, SRH services use, gender distribution, and location

Results

Participants' characteristics

As shown in Table 1, a total of 75 participants took part in this study, representing four selected sectors of Rwamagana district. Among them were 71 AGYW aged between 12 and 24 years, as well as 4 key informants (1 female and 3 males), who are the healthcare providers in charge of the youth corners. Among the participants, 47% were AGYW who had utilised SRH services offered at the youth corners, whereas the remaining 52% were AGYW who had never used the services.

Based on observations from the AGYW who participated in the FGDs and the reports, it was noted that the majority of individuals utilizing the youth centre were above 18 years old. Among the AGYW who had accessed the services, a significant proportion were enrolled in schools located near the center, while those who had not used the services were predominantly not attending school. Limited interaction was observed among the AGYW, with many of them not being acquainted with each other, except for those who shared the same school.

Themes

Upon the analysis of the FGDs with AGYW, KIIs, and the observation checklist, we identified four overarching themes related to the study objectives. The first theme, SRH services provided by youth corners to AGYW in Rwamagana, captured the range of services offered, including counselling, family planning, HIV testing, and referrals. The second theme, acceptability and utilisation of SRH services, reflected how AGYW perceived these services, the extent to which they felt comfortable seeking them, and patterns of use. The third theme, challenges to accessing SRH services, highlighted barriers such as stigma, limited awareness, stock-outs, and negative provider attitudes. The fourth theme, opportunities

to improve access, emphasised areas where service delivery could be strengthened, such as community sensitisation, youth-friendly training for providers, and expanding the scope of services available.

SRH services provided by youth corners

Available services in youth corners versus the needs of AGYW

Youth corners provide a range of services including counselling, HIV and STI testing, family planning (such as pills, injectables, and condoms), and information on body changes and menstrual health. However, AGYW reported that these services are not always consistently available due to irregular schedules and the presence of different healthcare providers across visits. This inconsistency often resulted in limited access to desired services.

The needs of AGYW primarily focused on confidential counselling, reliable access to family planning methods, and HIV/STI testing. Yet, they noted gaps, such as inadequate availability of condoms and inconsistent provision of comprehensive SRH information. In addition, AGYW highlighted the gendered nature of advice received in youth corners: while girls are often advised to avoid boys, no comparable guidance is directed toward boys.

> *"I recently advised the pharmacy manager to store condoms where people can find them, but there are not many condoms usually included in the services" (YCFP2).*
> *"In the youth corner we used to meet on Saturdays and Sundays. But right now, we meet on Friday after school, we pass by and ask some questions we might have." (AGYW, 19–24).*
> *"Other methods we use include pills, injectables; all those tools help in preventing unplanned pregnancies." (AGYW, 19–24).*
> *"They perform HIV/AIDS tests, and they tell you how to avoid boys" (AGYW, 19–24).*

During the observation, it was noted that the majority of youth corners had a designated and secure area, clearly marked with signage indicating its location, in accordance with the youth corners' SOPs. Prominently displayed near the entrance were posters featuring the focal person's contact information, available services, and operating hours. The interior walls of the youth corners were decorated with drawings illustrating the various SRH services offered, including family planning methods.

Acceptability and utilisation of SRH services by AGYW

Parents and religion negatively affect SRH service-seeking behaviour of AGYW

During the discussions, several AGYW, mainly from the rural areas of Rwamagana, shared that their parents and religious leaders perceived SRH services as incompatible with Rwandan culture. They mentioned that their parents believe that certain SRH services, such as family planning, are against their cultural values. Additionally, participants noted that specific religious beliefs resulted in opposing using certain SRH services, particularly family planning. These cultural and religious beliefs influenced the acceptability and utilisation of comprehensive SRH services by AGYW.

> *"Even parents can play a big role in it. There are parents who think that it is not appropriate in Rwandan culture. They may also prevent you from going there to access these services" (AGYW, 14–18).*
> *"However, for parents, they answer something and refuse to talk about some other topics or get shy about it" (AGYW, 14–18).*
> *"For example, in ADEPR [Association des Eglises de Pentecote au Rwanda].*
> *Whether you are a youth or an adult, they call it murder if you use family planning. They stop you from participating in church or the holy communion if you get caught. " (AGYW, 19–24).*

Furthermore, AGYW highlighted gender inequality within their own families, wherein girls are subject to different rules and expectations than their male siblings. This disparity creates additional hurdles for AGYW, as they navigate societal expectations and restrictions that are not equally imposed on their male counterparts. These gender-based discrepancies in family dynamics add further complexity, impacting the utilisation of SRH services by AGYW. This is what a sample of participants had to say about this gender-based discrepancy.

> *"Some parents only give rules and regulations for girls and show that among all the children they are only worried about adolescent girls. If the adolescent girl has a curfew to go home, it usually does not apply to the boys" (AGYW, 19–24).*
> *"If an adolescent boy drops out of school, it is because they want to. They usually even start their small businesses after. However, it is different for girls when they drop out, because they suffer more since they are always dominated" (AGYW, 19–24).*

Negative attitudes and misconceptions of the community impacting SRH utilisation by AGYW

During the discussions, most AGYW participants aged between 18 and 24, shared their concerns about the impact of the negative attitudes prevailing within their families and the wider community on their utilisation of SRH services. They reported that the overall negative attitude towards SRH services, including youth corners,

profoundly affected their willingness to seek and utilise these services. The participants noted widespread misconceptions associated with SRH services, leading people to immediately assume that individuals visiting these services were either seeking abortions or living with HIV/AIDS. This discouraged AGYW because they avoided being associated with their youth corner or SRH services.

> *"In the community, everyone discourages you from using pills if you are not married and living with the husband" (AGYW, 19–24).*
> *"They start saying that you have gone to ask for an abortion. I think that is the reason why I am afraid to go to the youth corner." (AGYW, 19–24).*

The overall negative perceptions and misconceptions surrounding SRH services, including youth corners, led to assumptions and stigmatisation, which is why AGYW expressed a fear of being associated with these services.

Privacy concerns with known healthcare providers and acceptability/Utilisation of SRH services

Most AGYW across both rural and urban settings of Rwamagana highlighted that when healthcare providers are known within the community, individuals may feel hesitant to freely express themselves, fearing a breach of privacy regarding their personal information. The privacy concerns underscore the necessity of creating an environment where AGYW can feel comfortable and confident in seeking SRH services without compromising their confidentiality. This was confirmed through the following statements.

> *"For example, most doctors here know me, so I get discouraged from coming because you are worried that they might expose your information" (AGYW, 19–24).*
> *"What I think is that sometimes the health facility is close to home, and the health providers there may be acquainted with our parents. Then, when you come to request the condom from the health provider, he/she will give it to you, but they will tell your parent that their girl has become insolent and she comes to ask for condoms" (AGYW, 19–24).*

Interestingly, a considerable proportion of AGYW expressed trust in healthcare providers' ability to maintain confidentiality, given their training and professional obligations. This sense of trust acted as a motivating factor for AGYW to be more open and forthcoming in utilising the available SRH services. AGYW's confidence in healthcare providers' commitment to confidentiality encouraged them to actively engage and seek the support they require without reservation. The AGYW participants had these to say.

> *"However, if you get a job, during the training you are given specific information about your position, you cannot say everything you have seen. There are things you can say and things you cannot" (AGYW, 14–18).*
> *"For me, my mum usually tells me that the first thing the health providers learn is to keep secrets, that is why I feel like there is nothing I can't tell a health professional" (AGYW, 19–24).*

The observation checklist noted that the youth corners provided a sense of privacy, with one of them even having two separate doors for entry and exit, ensuring confidentiality for AGYW.

AGYW's perspectives and approach towards SRH services

A few AGYW had certain expectations regarding the utilisation of services available at the youth corner, including the desire for financial compensation. Some AGYW believed that these services are relevant only if they have already given birth, whereas others mistakenly perceived SRH services as exclusively intended for unmarried individuals.

> *"Like when you tell someone to come with you to the youth corner to learn about SRH, they start asking if they will get paid. If there was money, many people would come." (AGYW, 19–24).*
> *"I think it is for people who gave birth when they were young" (AGYW, 14–18).*

Nevertheless, AGYW expressed the necessity for these services, specifically in the context of preventing unplanned pregnancies. They highlighted the crucial importance of accessing these services at an early stage to adequately equip themselves for future aspirations. AGYW stressed the importance of initiating the utilisation of these services as early as the age of 9, as that is when some of them commence experiencing menstruation. Furthermore, AGYW expressed that they also become sexually active at an early age, which exposes them to risks such as STIs, unplanned pregnancies, and HIV. By recognising the importance of early intervention, AGYW emphasised the need to establish a foundation of SRH knowledge and support from a young age to empower themselves in making informed decisions and promoting their overall well-being. Some participants shared the following.

> *"The youth service is for adolescents between the ages of 10 and 24, the 5-year-old children to*

10-year-old should also have their consultation and package so they can be provided with the services as well" (AGYW, 14–18).

"Reproductive health education for teenagers from 10–24 years old. We start from 15 years of age because they already have an onset of sexual intercourse, and they know when they are having their periods." (AGYW, 19–24).

Challenges to accessing SRH services in youth corners for AGYW

Lack of incentives for AGYW

AGYW endure considerable travel distances to access youth corners. Previously, monetary compensation for transportation incentivised attendance, yet presently, no such incentives exist. The financial strain associated with accessing transportation exacerbates this situation, as highlighted by AGYW. Moreover, with youth corners typically limited to one per sector, the logistical hurdles become more pronounced for some AGYW, further leading to a decline in SRH service uptake. Below are some of the statements from the youth corner focal persons.

"Children coming from a distance to get the services and needing transport tickets is another issue." (YCFP2).

"We were providing the incentive; we would see approximately 20 or 30 people per day; at times, we worked two shifts in a week. On days they were available, we would have approximately 50 people, and they would all be focused and follow the lessons diligently… In a week now we can receive like approximately 5 people." (YCFP1).

"The motivation is necessary because someone will not travel from a very distant place like Kagezi, for instance, and climb a hill just to get here, tired and not even get water to drink" (YCF3P).

AGYWs' poor level of knowledge of SRH

Throughout the discussions, the participants consistently highlighted the issue of limited information on SRH. The AGYW expressed a lack of knowledge about the existence of youth corners, the range of services provided, and the reasons why they should utilise these services. Additionally, misinformation further compounded the problem, as AGYW were exposed to inaccurate or misleading information that affected their perception of SRH services and their willingness to access them.

"I need this youth service because we learned it in class. However, because the teachers have few hours, they do not go into it as deeply as you want to understand" (AGYW, 19–24).

"It is hard for my colleagues because they do not have enough information or are scared and sometimes even think it is not necessary to go there [to the Youth Centre] because they are ashamed" (AGYW, 19–24).

AGYW also highlighted their reliance on alternative sources of information, which, unfortunately, are not always accurate or reliable. These include information on unverified online platforms such as Facebook, some pharmaceutical stores, and some NGOs. Despite the lack of assurance in the accuracy of these sources, AGYW felt compelled to seek information from them owing to limited access to more authoritative and trustworthy sources.

"The example of false information is that when a person uses some medical drugs, it can cause infertility, such as ibuprofen or diclofenac" (AGYW, 19–24).

"When you ask your friend to tell you the cure, she may tell you that when you have facial acne, you approach your boyfriend and have sex with him so the acne will go." (AGYW, 14–18).

Shortage of trained SRH healthcare providers discourages AGYW

A shortage of trained healthcare providers was identified by most participants, particularly YCFPs, as a critical issue, posing a direct impact on accessibility and the quality of SRH services. The limited number of staff members affected the operating hours of the youth corners, making it difficult for AGYW to access the services when they needed them. The youth corner's focal person expressed how other competing responsibilities at the health centre pushed them to compromise on the youth corner programs, sometimes forcing them to completely close the youth corner. Here is what some participants shared.

"We are few employees in the health centre, so you can plan your timetable and find that you might be needed to attend to another problem in the centre; we are few nurses, so it is difficult to attend to everyone; you would not plan to go to the mountains to teach the students when there are patients coming for treatment" (YCFP2).

"The challenge we see is that healthcare providers are allocated to different positions within the health centre, resulting in limited availability at the youth

corner. That is why the youth corner doesn't operate every day." (YCFP1).

Principal Investigators also observed that only one youth corner operated on Saturdays, while the other three remained closed on weekends. The centers were not overcrowded, and no clients seeking SRH services were observed at the time. Interestingly, one of the youth corners was being utilized for training community health workers (CHWs) as an alternative use of the space.

During the visits to the youth corners, it was observed that each centre had an assigned focal person, with one of them even having two GBV counsellors for support. However, these focal persons faced their own set of challenges. One of them, who was a pharmacist, had limited availability and rarely opened the youth corner. Another focal person was an older man in his sixties. Out of the observed focal persons, only one was female, while the rest were males.

Challenges with healthcare provider capacity and attitudes

The Youth Corner Service Providers (YCSPs) also expressed concerns about the competency of the available healthcare providers. They reported instances where these providers refused to offer services to AGYW on the basis of their visit frequency. Below is what the participants had to say.

"When they send her to the nurse after she comes back for the 2nd time, the nurse refuses to serve her, and she has to wait for me." (YCFP2).
"It is noticeable that there is a misconception and that the attitude of the service providers is not favourable" (YCFP3).

Challenges with comprehensive SRH service provision

Furthermore, certain youth corners lacked the capacity to conduct all the necessary tests. This posed a challenge for AGYW, who required additional services, as they had to seek assistance from other departments within the health centre. This situation created discomfort and inconvenience for AGYW, as they had to navigate through different departments to fulfil their healthcare needs.

"For example, your HIV status or pregnancy, all of that should be done in this room. We should not be sent in other areas to get the tests done" (AGYW, 19–24).
"When you come here you are thinking that all services will be given in this room but then they start sending you to go get some tests done down there, somewhere else" (AGYW, 14–18).

Abrupt sponsorship cessation on youth corner service provision and SRH service utilisation

According to the key informants, the establishment of youth corners initially received support from both the government and the INGOBYI initiative, a program supported by USAID. However, there was an abrupt halt to this support, which had adverse effects on the provision of services, outreach activities, and the motivation of healthcare providers. The participants mentioned that healthcare providers were receiving compensation as part of the support, and its discontinuation impacted their dedication and enthusiasm towards their roles.

"This means that they are actively monitoring it even though the sponsor has changed because his term has expired. This indicates that they are closely monitoring it (the youth corner), even after the sponsor's term has expired and a new sponsor has taken over." (YCFP1).
"As we told the head of the hospital, if we find a donor/sponsor who would support us, participation will increase, and we would educate more children about the many problems that girls tend to face, such as HIV infection in boys, pregnancy in girls is a big problem" (YCFP1).

Opportunities to improve access to SRH services via AGYW

Improving communication channels for SRH information delivery to AGYW

During the conversations, campaigns that appeal to young people while effectively conveying information about youth corners and SRH were recommended. The participants expressed a strong preference for community campaigns through events, highlighting their effectiveness in reaching and engaging the target audience. School campaigns were also deemed crucial, recognising the importance of reaching AGYW within educational settings for disseminating SRH information.

"They can also help us with media awareness and be our bridge with communication with other stakeholders" (YCFP4).
"I think that if they conduct a campaign in schools and other places where many people meet." (AGYW, 19–24).

Confidentiality and privacy systems are crucial for SRH services

Ensuring confidentiality and privacy in the provision of SRH services is of utmost importance, as emphasised by AGYW. They expressed the need for robust systems that safeguard the confidentiality of their personal

information. The physical location of the youth corner posed a significant barrier, as it discouraged AGYW from accessing the services due to the visibility of their visits. The perception among others in the community was that the services sought by AGYW could be easily assumed on the basis of their presence at the youth corner.

> *"For example, most doctors here know me, so I get discouraged from coming because you are worried that they might expose your information" (AGYW, 19–24).*
> *"Where the problem is, when you meet a doctor and determine that you know each other, maybe you are even neighbours, you cannot tell them everything because you meet in everyday life" (AGYW, 19–24).*

Community engagement for SRH awareness and support

Most AGYW participants stressed the importance of ongoing motivation and sensitisation efforts within the community to raise awareness about the significance of SRH services. They emphasised the need to involve various community stakeholders, including parents, local leaders, and religious leaders, in these initiatives. The participants recognised that sustained motivation and sensitisation efforts are vital for fostering a supportive environment that understands and values the importance of SRH services. By engaging community members and stakeholders, the aim is to promote understanding, acceptance, and active support for the access of AGYW to comprehensive SRH services.

> *"We devised a plan to educate parents in parenting groups, particularly mothers, because there are some children who are restricted to house chores" (YCFP4).*
> *"However, if healthcare providers take at least one day every week to teach in different villages, they can organise with local leaders to mobilise their youth. "(AGYW, 19–24).*
> *"As these programs have been positioned in health centres or schools, I would feel that it would be beneficial if they reached the religious community as well" (AGYW, 19–24).*
> *Overall, the participants recognised that sustained efforts in motivating and sensitising the community are crucial for creating a supportive environment that values and understands the significance of SRH services. By engaging community members and stakeholders, the goal is to foster understanding, acceptance, and active support for AGYW's access to comprehensive SRH services.*

Discussion

This study identified the various SRH services offered to AGYW at the youth corners, the factors influencing the acceptability and utilisation of SRH services in youth corners, and the challenges and opportunities for accessing SRH services at the corners of youth by AGYW. By applying the socioecological model, this study explored the intrapersonal, interpersonal, and institutional factors that participants highlighted as influential in shaping their attitudes and behaviors toward SRH services in youth corners. Feminist standpoint theory aided in centring on marginalised voices, analysing power structures and contextualising the experiences of AGYW in the Rwamagana district.

SRH service provision in youth corners

According to the findings, the SRH services offered in youth corners to AGYW encompass a wide range of options. The observation checklist revealed that these services include contraceptives, emergency contraceptives, pregnancy tests, HIV and STI testing and screening, ASRH information, post-GBV services, and counselling. These available services align with the minimum SRH services package outlined in the Youth Corner SOP. Notably, the decorative elements on the walls were consistent across all the youth corners.

In addition, the youth corners provide a safe room fully equipped with the necessary resources to deliver SRH services. However, it was observed that there were no condom dispensers readily available in the main area of the youth corners, requiring AGYW to request condoms directly from the service providers. This arrangement was identified as a barrier to accessing condoms. According to Casmir et al., inconsistent condom use occurs among AGYW, and the need to request condoms can further hinder accessing and using them [17].

The study also highlights the interpersonal barriers faced by AGYW in accessing SRH services, namely, that they are afraid of their parents knowing that they are sexually active. This aligns with previous research, which noted that teenagers perceive their parents "as authoritative figures who could react punitively towards them or be disappointed if they know about their sexual matters" [18]. This is cemented by findings by Mbarushimana et al., who posit that the Rwandan culture considers it taboo for adolescents to discuss SRH with their parents [19].

At the institutional level, AGYW fears judgement and confidentiality issues with service providers. Although in this study, the AGYW indicated that their confidentiality is generally maintained in health facilities, they also indicated that there are instances where confidentiality has been breached and that this discourages them from seeking services. These findings concur with those of a previous study that noted that AGYW face clinical stigma,

because of harsh, rude, and judgmental interactions that are lecturers in nature from clinical staff [20]. Nmadu et al. reported that health workers' behaviour and attitudes reflect the community; henceforth, with communities that are not supportive of AGYW SRH, it is difficult for AGYW to access and utilise services [21].

The study highlighted that one of the major challenges in accessing and utilising SRH services in the youth corner is that there is a shortage of trained personnel to provide youth-friendly SRH services to AGYW. Geary et al. argue that training health providers in youth-friendly services assists health workers in distinguishing between personal beliefs, values, attitudes and professional duties and standards [22]. This is an integral part of SRH service provision, especially for AGYW; thus, service providers are to be trained on confidentiality and being nonjudgmental, among other key aspects of youth SRH, to meet the specific needs of AGYW [22].

In one of the health centres under study in Rwamagana District, a pharmacist was working as both a pharmacist and a youth focal person. As a result, there was a lack of prioritisation of the youth corner, as it was closed most of the time, as the health worker was always at the pharmacy. This deterred AGYW from arriving at the health facility, as they knew that the youth corner was always closed. This is in contrast with the Youth Corner SOP, which states that the youth corner must have 1 permanently trained staff member on youth-friendly services who has technical competence. Failure to adhere to the guidelines of the Youth Corner SOP means that AGYW in the area are highly likely to be attended to by a person not trained in youth SRH service provision. Furthermore, key informants indicated that they are assigned other tasks; hence, the youth corner becomes secondary, which is affecting its utilisation and availability of services to AGYW.

SRH service acceptability and utilisation

The study revealed that there are misconceptions about SRH services, as some AGYWs regarded it as a service needed by those who have given birth. This is driven mainly by what they have witnessed happening in their locality. Only AGYW who have given birth were offered most pregnancy prevention methods, whereas those who have not given birth were mostly given condoms. Most of the participants in the FGDs highlighted a lack of knowledge of SRH and services at youth corners.

AGYW expressed a lack of knowledge about the SRH services provided at the youth corner and the importance of utilising youth corners. This is in accordance with a study by Helamo et al., who reported that young people with a lack of knowledge of youth-friendly SRH services may not seek out these services, even when they are in need of them [23]. This confirms what Jonas et al.. discovered in a study on perceptions of contraceptives, that one major barrier to the use of SRH services by AGYW is a lack of knowledge [24]. As such, there must be intentional targeting of AGYW through comprehensive sexuality education (CSE) both in school and outside of school to equip them with knowledge and skills related to SRH. According to Mukandagano et al. and George et al., CSE helps in reducing risky behaviours among AGYW [25, 26].

On the other hand, the study revealed that young people believe that SRH services are an essential component of their adolescence; thus, they must start accessing information from as young as 9 and 10 years of age, as one of the participants (*AGYW, 19–24)* expressed. Mcharo et al. support this notion by stating that introducing SRH education at an earlier stage in life benefits young people by addressing misconceptions and preventing risky sexual behaviours [27].

The study revealed that culture, religious beliefs, and parents play important roles in influencing decision making on the utilisation and acceptability of SRH services. The AGYW expressed that their parents hold the view that certain SRH services, such as family planning, are against their cultural values. Ndayishimiye et al. noted that the negative attitudes of family members discouraged adolescents from accessing SRH services as they were faced with stigmatisation and shaming [8]. This is supported by Mbarushimana et al., whose findings state that it is taboo for parents to talk to adolescents on SRH; thus, SRH is only for married individuals [19]. According to Ram et al., families that have made efforts to talk about or promote the access of AGYW to SRH focus mainly on reprimanding them on abstinence and prevention of unwanted pregnancy [28].

With limited financial resources and no support from parents, AGYWs face the challenge of either requesting transport money from their parents or walking to the health centre. Asking for transport money from parents means that the AGYW must now disclose why they are seeking SRH services to their parents. Owing to cultural norms, most parents, even those who are well-to-do, do not support their AGYW financially to access SRH services. This aligns with the arguments put forth by Mbarushimana et al. that discussing SRH matters with adolescents is culturally unacceptable and perceived as promoting prostitution [19].

Additionally, participants articulated that specific religious beliefs also oppose the use of certain SRH services. The participants stated that some religious beliefs, such as (ADPR) *Association des Eglises de Pentecote au Rwanda*, forbid people from using family planning because they view it as murder. They also stated that if family planning use is discovered, people are banned from participating in specific church practices, such as

holy communion. These articulations concur with findings by Asiimwe, who argued that most Rwandese are Catholics and, as such, that religion discourages the use of contraceptives [6]. Scholars such as Somefun et al. posit that religion has a positive influence on adolescent SRH, as it promotes abstinence for the avoidance of teen pregnancies [29]. For AGYW in Rwanda, the utilisation of SRH services is also a challenge, as 50% of health facilities in Rwanda are supported by the Catholic Church and other religions; as such, they fail to offer reproductive health services such as contraceptives and abortion services to AGYW [8].

Obstacles in provision of SRH

This study highlighted that there has been a lack of sustainability in funding youth corners, which has affected how young people access services. In the study, AGYW highlighted that some services are no longer available at the youth corner; as such, there is nothing compelling them to access services. These unavailable services include stipends for AGYW, who have travelled long distances to come to the youth corner, and outreach information dissemination sessions. Without these outreach activities, it has become difficult for AGYW to access information on SRH, especially information for those out of school. When AGYW do not have correct information on SRH, they could make uninformed decisions that lead to negative SRH outcomes.

The study also revealed that most of the information dissemination strategies target adolescents who are in school and thus neglect those who are out of the school system. A study by Janighorban et al. revealed that AGYW who are out of school are the most vulnerable to teenage pregnancy and new HIV infection [30]. As such, this strategy of only targeting those in schools during the outreaches further increases the vulnerability of AGYW who are out of school.

Moreover, the selected approach in service provision, whereby AGYW are mostly given condoms when they do not have children and a wide variety of contraceptive methods when they have given birth, limits the choice for AGYW. The Rwandan Family Planning Policy stipulates that AGYW are entitled to have a choice in the type of contraceptive that they need, therefore limiting them to only condoms infringes on their right to choose. While the right to choose is withheld, this fuels negative SRH outcomes, as the utilisation of these services is directly impacted. This is confirmed by a study conducted in Kenya that noted that consistent condom use among AGYW is a challenge [17]. As such, the use of condoms as the primary prevention strategy will lead not only to teenage pregnancies but also to high HIV incidence. Daniel et al. reported that more AGYW mothers are worried about pregnancy prevention rather than STI/HIV infection or prevention [31].

Improving access to SRH for AGYW

The participants of the study indicated that there are limited outreach activities targeted at promoting SRH services among AGYW. School campaigns were also crucial, as they recognised the importance of reaching AGYW within educational settings. The dissemination of SRH information empowers AGYW to make informed choices and decisions about their SRH.

The study also indicated that there is a need to train health care providers in the provision of youth-friendly services. This training ensures that service providers meet the unique needs of young people, enhances the quality of care, and empowers young people to access services. Moreover, it helps providers understand the developmental stages, psychosocial challenges, and concerns that young people face, enabling them to deliver care in a sensitive and age-appropriate manner. This aligns with what the UNFPA advocates for to ensure access to AGYW and to utilise SRH services.

Sociocultural norms were highlighted as contributing to stigmatisation and discrimination against AGYW seeking SRH services. Topics related to sexuality, contraception, or STIs were considered taboo or immoral in communities, including religious spaces. By addressing these norms, the stigmatisation surrounding SRH issues can be challenged, and a safe, supportive, and comfortable environment can be created for AGYW to access SRH services [32].

Strengths and limitations of the study

A key strength of the study is its qualitative design, which allowed for in-depth exploration of participants' experiences, perceptions, and context-specific factors influencing access to SRH services. The inclusion of both AGYW and youth corner focal persons provided a more comprehensive understanding of the topic.

However, the qualitative approach also presents limitations, it captures rich, detailed insights but does not allow for statistical generalisation of findings to the broader AGYW population in Rwamagana or Rwanda. A follow-up quantitative study could help quantify the prevalence and magnitude of the identified challenges.

The study venue may have influenced participant responses, potentially limiting the depth of their views and perceptions. This was reduced by guaranteeing the participants that it was a safe space and that they could freely express themselves. Furthermore, the nature of the topic was sensitive and personal; hence, there is a possibility that participants shared responses that are socially acceptable, especially questions on needing SRH services and their experiences accessing SRH services from the

youth corner, as well as who/what influences them to access SRH services in the youth corner. This was averted by reminding participants of the nondisclosure clause and guaranteeing that the participants were safe. The scope of the study focused on intrapersonal, interpersonal, and institutional factors, and policy reviews were not included in this study, as they were not a recurring theme, and this can be considered in a future study. However, the findings of this study are important for revealing the perspectives of AGYW on the acceptability and use of youth corners to access SRH services.

Conclusion

The findings from the discussions with AGYW and youth corner focal persons highlight several key challenges and concerns regarding the utilisation of SRH services. These challenges encompass various aspects, including inconsistent availability of services, mismatched healthcare provider preferences, limited budgets, negative attitudes within the community, and barriers related to transportation and accessibility. Addressing these challenges is crucial for promoting the effective utilisation of youth corners and comprehensive SRH services among AGYW.

The study's findings emphasise the importance of addressing various challenges and concerns surrounding the utilisation of SRH services by AGYW at youth corners. Some of the proposed areas of improvement include the need for consistent availability of services, addressing healthcare provider preferences, recruiting, training youth-friendly healthcare providers, community sensitisation, information dissemination, and improving the quality of SRH services provided at the youth corner. These efforts will help empower AGYW, promote their well-being, and enable them to make informed decisions about their sexual and reproductive health.

Abbreviations

RARP	Robot-assisted radical prostatectomy
ePLND	Extended pelvic lymph node dissection
ADT	Androgen deprivation therapy
PSA	Prostate-specific antigen
SD	Standard deviation
ICS	International Continence Society
PSMA	Prostate-specific membrane antigen
PET-CT	Positron emission tomography–computed tomography
NHT	Neoadjuvant hormonal therapy
PROMs	Patient-reported outcome measures
EPIC-26	Expanded Prostate Cancer Index Composite

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

PI and NTS analysed and interpreted the data collected during the study protocol, with advisory guidance from TY. PI led the data collection, while NTS spearheaded the analysis alongside PI. TY was a major contributor in writing the manuscript. All authors read and approved the final manuscript.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This study was approved by the University of Global Health Equity Review Board (UGHE IRB) with the reference number UGHE-IRB/2023/018. Additionally, we received approval from the National Health Research Committee of the Ministry of Health, referenced as NHRC/2023/PROT/023.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Publisher's Note

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