Since its creation in 2007, the Imbuto Foundation has focused on improving adolescent sexual and reproductive health (ASRH) outcomes for youth in Rwanda. In response to emerging government interest in ASRH issues and the lack of targeted efforts addressing these issues, the Imbuto Foundation (“Imbuto”) launched a comprehensive ASRH initiative in 2010. The initiative involves both policy and programming efforts to increase access to ASRH information and services and improve ASRH-related knowledge, attitudes, and practices.

Supported by the David and Lucile Packard Foundation, Imbuto’s ASRH initiative aims to facilitate national policy and programmatic action to promote ASRH and test a new community-level approach to improving ASRH-related knowledge, attitudes, and practices (KAP) in two districts in Rwanda (Gicumbi and Nyarugenge).

At the policy level, Imbuto facilitated the establishment of an ASRH technical working group (TWG) under the Maternal and Child Health division of the Ministry of Health (MoH). The TWG is chaired by the MoH and cochaired by Imbuto, and includes several government and nongovernment stakeholders working on ASRH issues. The TWG helped develop and is supporting implementation of a national ASRH policy, which includes specific guidelines and action items for improving ASRH education and outreach and strengthening the provision of facility-based ASRH services (including provider training on a newly defined ASRH minimum service package and the establishment of youth corners at health facilities). Imbuto has also helped form district-level ASRH committees, which include district social affairs, health, education, and youth council officers.

To further support government ASRH efforts, Imbuto also developed and launched a community-level program to promote positive ASRH behaviors among youth in targeted communities. The program leverages the framework and service delivery changes generated through the ASRH policy process and uses peer educators, schools, youth councils, and facility nurses as community change agents. It has three interlinked components: (1) creating youth ASRH clubs, (2) linking ASRH clubs to health facilities, and (3) promoting parent and community engagement (see left). The program was developed and piloted by Imbuto and IntraHealth.

**ASRH Program Components**

1. **CREATE ASRH CLUBS**
   - Clubs are created for in- and out-of-school youth aged 10-24 years at schools and through cell-level youth councils.
   - Clubs are run by trained club mentors (teachers or sector youth council coordinators) and club presidents (older youth).
   - Members include 20 trained peer educators and recruited youth.
   - Clubs meet regularly and conduct information, education, and communication (IEC) sessions for non-club youth.
   - Mentors and presidents provide individual counseling to members.
   - Out-of-school clubs conduct income-generating activities.

2. **LINK CLUBS TO FACILITIES**
   - Nurses are trained on provision of youth-friendly ASRH services.
   - Clubs are connected with trained nurses, who help train peer educators and participate in club IEC sessions.

3. **ENGAGE PARENTS AND BROADER COMMUNITY**
   - Clubs organize one-off community outreach events.
   - School clubs hold parent-adolescent communication (PAC) workshops.

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**Figure 1. Overview of the Imbuto Foundation’s ASRH Initiative**
in 2010 and scaled up in Gicumbi and Nyarugenge districts between 2012 and 2014 with support from the David and Lucile Packard Foundation.

This brief summarizes the findings of the evaluation of Imbuto’s ASRH initiative. The evaluation assessed the implementation, outcomes, sustainability, and scalability of the initiative. It also sought to identify key lessons learned and offer recommendations on how to reach and engage youth in ASRH efforts. The study relied primarily on the collection and analysis of in-depth qualitative data, triangulated with program monitoring data. Qualitative data from club members, nonclub youth, and parents were collected through focus group discussions (FGDs). In-depth interviews (IDIs) were conducted with club mentors and presidents, health center staff, Imbuto program staff, government officials, and development partner representatives. A total of 58 FGDs and 56 IDIs were conducted with 512 respondents.

**INFLUENCE ON THE NATIONAL ASRH AGENDA**

The ASRH TWG drew attention to ASRH issues among key stakeholders. In response to the MoH’s growing interest in ASRH, Imbuto suggested forming an ASRH TWG and offered to cochair and support it. Launched in 2010, the TWG brought together diverse stakeholders from multiple sectors for the first time to discuss ASRH. In doing so, it fostered greater recognition of unmet ASRH needs and expanded ASRH dialogue and programming efforts to encompass different sectors and areas. The TWG has been called on by other national working groups focused on related topics—such as community health and gender-based violence—to provide input on how to better serve youth under various programs and initiatives.

The TWG also catalyzed coordinated action to address ASRH issues, including development of a national ASRH policy. The TWG provided a central platform for coordination and joint action to support ASRH. Through its discussions of existing programs and screening of new programs, the TWG has helped to reduce duplication of effort, fill programming gaps, and strengthen programs. The TWG also provided critical financial and technical input to support the formulation and implementation of the national 2012 ASRH policy. Imbuto, along with other TWG members, funded a rapid landscape assessment to inform formulation of the policy, supported review workshops to refine the policy, and helped create tools (including a provider training manual) to facilitate policy implementation.

Implementation of the 2012 ASRH policy is underway, but key elements require more attention and resources. Health providers across the country have been trained on the minimum ASRH service package, with Imbuto providing direct support for trainings in 17 districts. However, as of 2014, only a small proportion of health centers are providing youth-friendly ASRH services in accordance with the national policy, and only about a half have functional youth corners (MoH 2014). In addition, ASRH experts interviewed for this study noted the need for enhanced outreach to youth in rural areas, young men and boys, and at-risk populations, such as youth with disabilities.

**PROGRAM IMPLEMENTATION SUCCESSES AND CHALLENGES**

Under its community-level ASRH program, Imbuto established 263 active, self-sustaining ASRH clubs. Using the national ASRH training manual and master trainers selected by the MoH, a total of 138 club

**Implementation Highlights**

- A total of 107 school clubs and 156 out-of-school clubs have been created in the project’s two target districts.
- Clubs include an average of 30 members and conduct meetings from 2 to 3 times a week to twice a month.
- Clubs conduct weekly or monthly IEC sessions that have reached a large number of nonclub youth, with an average of 45 youth per school club IEC session.
- Meetings and IEC sessions cover a range of ASRH topics, including puberty, prevention of unwanted pregnancies, prevention of HIV and sexually transmitted infections (STIs), and gender-based violence.
- Clubs are conducting a variety of outreach activities for other youth not involved in the club, parents, and community members. These include theater, music, dance, and sports events that integrate ASRH messages.
- School clubs have each conducted two PAC workshops to facilitate dialogue between youth and parents regarding ASRH issues.
- Imbuto trained 124 nurses in youth-friendly ASRH service provision, strengthening their recognition of the unique SRH needs of adolescents, and increasing their capacity to adapt services to meet these needs.
mentors (107 teachers and 31 sector youth council coordinators) and 263 club presidents have been trained on ASRH topics. With the assistance of these mentors and presidents, 107 school clubs and 156 out-of-school clubs have been established across all 31 sectors in Gicumbi and Nyarugenge districts. Clubs have an average of 30 members, including 20 peer educators trained by nurses, club mentors, and club presidents. Using a peer educator manual provided by Imbuto, mentors or presidents lead club meetings on a regular basis, from two to three times per week to twice a month, as well as weekly or monthly information, education, and communication (IEC) sessions that include nonclub youth. They also conduct a variety of outreach activities targeting parents and other community members. For school clubs, these include parent-adolescent communication (PAC) workshops.

As part of the program, 124 nurses were trained in youth-friendly ASRH service provision. Using the ASRH training manual and trainers selected by MoH, nurses at all health centers in Gicumbi and Nyarugenge were trained on ASRH service provision under the community-level program. Nurses have been linked with clubs and provide support for select club meetings or IEC sessions, sharing information on ASRH services at facilities and other SRH topics.

Club members are enthusiastic about the program. Club members note that the clubs are an improvement over other sources of ASRH information, such as radio programs or magazines, because they are interactive—allowing for questions to be asked and answered. They also appreciate the clubs’ supportive environment, in which they can discuss ASRH topics without embarrassment or shame. They particularly appreciate being able to seek confidential advice on SRH concerns through one-on-one counseling provided by club mentors and presidents.

Clubs have reached a large number of nonclub youth through their IEC sessions and community outreach activities. Club members invite peers to attend regular IEC sessions—program data indicate that an average of about 45 nonclub youth attend school club sessions. They also conduct diverse outreach activities, including theater, music, dance, and sports events that integrate ASRH messages; presentations for schoolwide assemblies or individual classes; and public competitions and debates to increase awareness of and discussion around ASRH issues. Club members also report speaking informally with their peers about ASRH issues.

School clubs are more engaged in ASRH efforts than out-of-school clubs, which tend to prior-

ize income-generating activities. School clubs tend to meet more frequently than out-of-school clubs and conduct more structured meetings, combining instruction on specific ASRH topics with interactive discussions. In contrast, out-of-school clubs conduct shorter, less frequent discussions with limited facilitation. A key driver of this difference is the focus on income-generating activities in out-of-school clubs, whose members tend to be older and have pressing livelihood needs. School clubs also tend to receive more support from nurse focal points and mentors (school clubs each have one dedicated mentor versus out-of-school clubs, which share mentors with other clubs).

School clubs’ parent outreach efforts tend to be infrequent and have limited reach. At the time of data collection, most school clubs in our sample had conducted two PAC workshops in the three to four years since their establishment. Workshops were attended by only a handful of parents—generally parents of 15 club members. Out-of-school clubs are not expected to conduct any PAC workshops (Imbuto focused its PAC-related efforts on school clubs).

Fear of parental disapproval and competing priorities limit club membership. Students and out-of-school youth are hesitant to join the clubs because they fear their parents will disapprove of an activity that involves discussion of taboo topics, such as sexuality and contraception. Many youth also have limited time to participate in the ASRH clubs. Several students, especially young women, cannot attend club meetings because they take place after school, when they are expected at home to help with household chores. Some students do not join the clubs due to their participation in other extracurricular activities available at schools (of which there are many).

Leadership and training gaps can affect club performance. Club members noted that mentors do not always attend meetings, due largely to competing demands on their time. As a result, club management and meeting facilitation are often left to club presidents—several of whom are new to the role and did not participate in Imbuto’s original training. As a result, some club presidents feel ill-equipped to educate their peers on ASRH.

Limited IEC materials have constrained club capacity to engage youth. Clubs have found the peer educator handbook provided by Imbuto useful, but have each only received a handful of copies (which members must share). They also do not have access to any additional IEC materials. Without different education tools to draw on, club leaders have found it challenging to sustain the interest of club members and engage nonclub youth in multiple IEC sessions.
activity. Instead, they promote abstinence as the best option, but stress that contraception should be used if youth feel they cannot delay sex. Several club members, both males and females, seem to have internalized this two-part message. However, some continue to feel that access to contraceptives could encourage sex and a few still believe that use of certain contraceptives can lead to infertility.

Greater awareness of and changes in provision of ASRH services at facilities have influenced youth perceptions of SRH services. Several health centers have established youth corners where young people are able to receive ASRH services confidentially. Health center staff also seem to be tailoring service provision to youth needs and preferences. These changes, combined with ASRH clubs’ interaction with nurses and promotion of SRH services at facilities, have helped reduce youth concerns about seeking ASRH services at health facilities. Several club members report that they visit health centers to seek medical advice on ASRH issues, obtain condoms, and/or get tested for HIV. Many young women visit the health center to obtain cycle beads or when they are experiencing menstrual pain or irregular periods, and young men often seek circumcision services. Program data also indicate an upward trend in service use across the two target districts (see Figure 2). Although these trends cannot be attributed to the Imbuto program alone, they are consistent with members’ reports of feeling more comfortable about seeking SRH services at facilities, suggesting the program is contributing to these trends.

**PROGRAM INFLUENCE ON KNOWLEDGE, ATTITUDES, AND PRACTICES**

Clubs have helped dispel common myths and misconceptions among their members. Club activities have been particularly successful in helping youth understand that certain beliefs regarding ASRH topics are inaccurate. Club members of a range of ages report learning that the following four myths are untrue: (1) children are born through the navel or mouth, (2) if an adolescent boy does not have sex, his penis will not grow; (3) engaging in sexual activity can cure acne and reduce menstrual pain; (4) one can conceive only at night.

The program has increased youth comfort with and peer communication on ASRH topics. Club leaders encourage youth to overcome their inhibitions and ask questions during club sessions. Club members report feeling much more comfortable discussing SRH topics with peers since joining their clubs. This has, in turn, reduced youth anxiety and shame about physical changes to their bodies and increased their willingness to seek SRH information and services.

Existing views favoring abstinence are strong, but the clubs have increased understanding of the benefits of family planning for preventing unwanted pregnancy. Nurses and mentors are concerned that promoting contraceptive use will encourage sexual activity before marriage and with multiple partners. However, they almost never relay abstinence only messages, despite the strength of local norms discouraging premarital sexual activity. Instead, they promote abstinence as the best option, but stress that contraception should be used if youth feel they cannot delay sex. Several club members, both males and females, seem to have internalized this two-part message. However, some continue to feel that access to contraceptives could encourage sex and a few still believe that use of certain contraceptives can lead to infertility.

**Figure 2. Facility-Based Provision of ASRH Services**

![Figure 2. Facility-Based Provision of ASRH Services](image)
Distance, limited availability of nurses, and traditional beliefs regarding abstinence continue to deter some club members from seeking services at health centers. Some health centers have large coverage areas and are difficult for youth in remote regions to reach. In addition, many nurses are overworked and are not able to prioritize service provision to youth—resulting in long wait times discourage youth from visiting health centers. Finally, community norms discouraging premarital sex also inhibit some club members from seeking facility-based ASRH services.

Nonclub youth still have pressing ASRH needs. Club members report filling gaps in their peers’ knowledge of ASRH and encouraging responsible decision making regarding sexual relationships. That said, nonclub youth still face considerable challenges in communicating with others about ASRH and are reluctant to seek facility-based ASRH services. The program’s relatively weak influence on this population might be explained by two factors. First, though clubs may have reached many nonclub youth, these individuals have varying levels of exposure to club IEC efforts. Second, nonclub youth are likely a different population than club members. For instance, they may be less interested in ASRH and/or receive less parental support for engaging in these issues.

Parents of club members still find it challenging to discuss ASRH issues with youth. PAC workshops have been successful in getting parents to reexamine traditional views that discourage discussion of SRH topics with youth. However, given the limited reach of PAC workshops, few parents have been able to overcome the culture of silence around these issues and have productive conversations about SRH with their children.

Program Sustainability

ASRH clubs are conducting activities independently, without intensive oversight from Imbuto. Imbuto is testing a light touch approach to program implementation, providing training and technical support upfront and ongoing financial assistance, but otherwise relying on schools and youth councils to implement program activities on their own. Despite this relatively low level of support, clubs are taking the initiative to conduct key ASRH education and outreach activities. They are meeting regularly; conducting IEC sessions for nonclub youth; and holding outreach events for nonclub youth, parents, and community members.

Out-of-school clubs that engage in income-generating activities are highly sustainable. Income-generation and savings activities have been helpful in ensuring that out-of-school youth do not leave the club—once they have contributed savings and had the option of drawing on pooled funds for emergencies, they are reluctant to leave. Income-generating activities have seen varying levels of profitability but ensured that youth remain connected to the clubs—to check in on their investments and to come up with strategies to increase revenue.

School staff concerns about promoting contraception and competing extracurricular activities may threaten program sustainability in school settings. Students generally have many extracurricular options to choose from and may prefer more traditional activities to the ASRH clubs. Schools also may not present a strong enabling environment for the program, given concerns from school principals and other teachers about the suitability of sharing ASRH information with youth and encouraging them to discuss these issues with each other.

Mentors and nurses may lack the time and capacity needed to strengthen and sustain program influence. These stakeholders report having a heavy workload and limited time to participate in club activities and serve youth.

Clubs would like more technical support and visits from Imbuto. Mentors feel they could benefit from additional training on ASRH topics, and also want more diverse IEC materials. Some would like Imbuto to visit the sites more often. They report that club members are particularly active and engaged when Imbuto is in attendance.

Emerging Learnings

Peer education needs to be supplemented with nurse- and mentor-led instruction to improve knowledge of ASRH concepts. Open dialogue among peers has helped dissolve the narrative of shame that surrounds puberty and sexuality and build mutual respect, particularly between young men and women. That said, peer education has been less effective in filling gaps in youth knowledge of critical aspects of ASRH. Club presidents feel ill-equipped to provide information on all ASRH topics and generally look to the mentors to fill this role.

Integrating income-generating activities into ASRH programs can increase participation among out-of-school youth, but also overshadow IEC efforts. Economic empowerment activities can be a powerful tool for increasing the engagement of out-of-school youth in ASRH programs—and may have indirect effects on ASRH outcomes—but need to be carefully modulated to ensure that ASRH education and learning continue to be prioritized by clubs.
Youth consider ASRH services youth-friendly when they ensure confidentiality and are provided without judgment. Given deeply rooted cultural beliefs condemning premarital sexual activity and contraceptive use, youth greatly value the privacy provided by youth corners and tend to seek care only at health centers when they can be sure of the provider’s discretion. Youth are also sensitive to any perceived judgment on the part of providers when they are discussing ASRH topics. They are most inclined to open up with questions and concerns when nurses are sympathetic, supportive, and accepting of their situation.

Sustained parent outreach is needed to produce meaningful shifts in sociocultural norms. Parents often said “it is not our way” or “against our culture” to discuss sexuality and reproduction openly, particularly with adolescents who are not married. These are deeply entrenched views and are unlikely to shift without persistent IEC and engagement efforts—which PAC workshops only provide to a limited extent.

KEY RECOMMENDATIONS

Devise strategies for expanding club membership. Clubs reach many nonclub youth through IEC sessions and outreach. However, given that the program’s influence on youth KAP is strongest among club members, the program may want to consider refining or widening recruitment efforts to integrate as many youth as possible into the clubs.

Equip clubs with more IEC materials and ensure they are age-appropriate. While club leaders find the existing peer education handbook helpful, they would like additional, ideally audiovisual, tools for disseminating key ASRH messages. They feel more tools would maintain club members’ interest in the subject matter and help clubs engage nonclub youth. Imbuto could consider generating separate sets of messages for different age groups. Some respondents note that information related to STIs and contraception may not always resonate with younger adolescents.

Identify mechanisms that will support club sustainability at schools. Rwanda is rolling out a new school curriculum that includes comprehensive sexuality education. The introduction of the new curriculum could serve as a vehicle for strengthening awareness among school staff of the importance of discussing ASRH with youth, and building support for the ASRH clubs. Imbuto could also ensure that existing school guidelines that incorporate ASRH items—such as the national school health strategic plan—are disseminated and understood by school staff.

Facilitate consistent and expanded provision of ASRH services at health centers. In the long term, health center capacity constraints inhibiting provision of youth-friendly services will need to be addressed at the policy level—which the ASRH TWG could advocate for through its ongoing national stakeholder engagement efforts. In the short term, Imbuto could consider providing refresher trainings for nurses that underscore the importance of outreach to youth and youth-friendly service provision for improving local SRH outcomes. ASRH service provision could also be integrated more systematically into VCT campaigns in order to increase service coverage.

Develop and implement additional parent outreach strategies. To increase outreach to parents, Imbuto could consider working with the Ministry of Gender and Family Promotion to incorporate discussions of ASRH into “parents’ evenings”, monthly village-level discussions focused on strengthening families and tackling local social sector challenges. Imbuto could also leverage the monthly Umuganda days to disseminate ASRH information to a large number of parents. Finally, Imbuto could consider training a cohort of parents to act as role models who sensitize other mothers and fathers to the importance of starting a dialogue with youth on these issues.

Intensify monitoring efforts to increase accountability and motivation. Imbuto could leverage its monitoring system to more closely track facility- and club-level program activities. For instance, the program team may want to collect monitoring data on indicators such as nurse participation in club meetings and IEC sessions, and build reflection points into its management plan for reviewing and acting on this data. Imbuto could also consider conducting site visits more frequently to help ensure that club mentors and nurses are actively supporting clubs’ IEC efforts.

Increase district government involvement in the program to promote sustainability. District officials displayed a high level of interest in the program. They have developed division-specific action plans to track the progress of program activities in their district and participate in the quarterly reporting sessions organized by Imbuto. Imbuto could leverage this interest to integrate district officials more closely into program management and oversight, which could strengthen program sustainability.

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