ASSESSMENT OF BARRIERS AFFECTING TEEN PREGNANCY PREVENTION IN RWANDA

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Sage SEMAFARA
Executive Secretary of RRP+

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List of Abbreviations

ABASIRWA	Abanyamakuru Barwanya SIDA mu Rwanda (Rwanda Media Network against HIV/AIDS)
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CLADHO	Collectif des Ligues et Associations de Défense des Droits de l'Homme au Rwanda
NISR	National Institute of Statistics Rwanda
CSOs	Civil Society Organizations
GBV	Gender Based violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GLIHD	Great Lakes Initiative for Human and Development for all
HDI	Health Development Initiative
HIV	Human Immunodefiency Virus
IPEACE	Initiatives for Peace and Human Rights
MIGEPROF	Ministry of gender and Family promotion
MINEDUC	Ministry of Education
MOH	Ministry of Health
MYCULTURE	Ministry of Youth and Culture
NISR	National Institute of Statistics of Rwanda
RBC	Rwanda Biomedical Centre
RCSP	Rwanda Civil Society Platform
RDHS	Rwanda Demographic and Health Survey
RICH	Rwanda Interfaith Council on Health
RRP+	Réseau Rwandais des Personnes Vivant avec le VIH/SIDA
RWAMREC	Rwanda Men's Resource Centre
SRH	Sexual and Reproductive Health
UNFPA	United Nations Population Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

Teenage pregnancy is becoming generally a complex challenge at global level with high rates in developing countries. Statistics within the East African region speak volume. Despite efforts invested in addressing teen pregnancy in Rwanda, there seem to be persistent challenges to achieving expected results. Being a complex subject, the overall aim of this assessment was to identify barriers affecting teen pregnancy prevention in Rwanda. In order to understand the barriers affecting teen pregnancy prevention, a descriptive design and qualitative methodology were used. A desk review, interviews with duty bearers and right holders were conducted to collect relevant information. The interviews included key informants from Central and local government institutions, civil society organizations as duty bearers and teen mothers as right holders. A single district with the highest prevalence of teen pregnancy was selected in each province and City of Kigali.

The assessment reveals a set of barriers that affect teenage pregnancy prevention:

- Lack of strong coordination between Government institutions and Civil Society Organizations (CSOs) implementing teen pregnancy prevention interventions;
- Gaps in the Human Reproductive Health and Medical Professional Liability Insurance laws that limit healthcare professionals from providing health services to under 18 years old without consent of a parent or legal guardian;
- Lack of implementing instruments to support the implementation of policies and laws. For instance, ministerial orders supporting Human Reproductive Health law, operational plans for ASRH, support mechanism to young girls who dropped out of schools due to pregnancy;
- Church-based health facilities that are not supportive of the provision of modern family planning methods;
- Teenage pregnancy prevention interventions focusing more on girls than boys;
- Limited SRH knowledge of adolescents and parents;
- Lack of discussions on sexuality related topics between parents and children;
- Negative attitudes of some Rwandans towards modern family planning use among unmarried women;
- Divergent views of CSOs on modern family planning methods among adolescents.

In light of the above findings, there is a need to:

- Strengthen coordination between government and implementing partners in the area of teen pregnancy prevention;
- Bridge the existing gaps in the Human Reproductive Health and Medical Professional Liability Insurance laws;
- Advocate for the development of implementing tools (Ministerial orders, operational plans);
- Strengthen secondary health posts to fill the gap of church-based health facilities in the provision of modern FP methods;
- Design inclusive SRH interventions targeting both adolescent girls and boys;
- Establish parent peer education approach to promote parent-child discussions on SRH topics;
- Develop age-specific SRH educational materials for both parents and teachers to facilitate transfer of knowledge
- Organize a yearly consultative dialogue on teen pregnancy with all actors including religious leaders, adolescents and right holders, and CSOs to have a collective consensus in addressing teen pregnancy.

I. INTRODUCTION

1.1. Background

Teen pregnancy remains a complex concern around the world despite efforts undertaken by governments and their stakeholders. An estimated 21 million adolescent girls aged between 15-19 get pregnant every year while 57% of them give birth[1]. However, developing countries are more affected; 83% of unintended pregnancies occur each year among girls of 15-19 years old and 777,000 births come from girls younger than 15 years in these countries[2]. The overall prevalence of adolescent pregnancy in Africa is 18.8%, higher in Sub-Saharan Africa (19.3%) and highest in East Africa region (21.5%)[3].

In Rwanda, available data seem to suggest an increase of teen pregnancies. From a rapid assessment conducted in 2016 in 10 districts, around 818 teenage girls got pregnant before the age of 18 years within a period of only two years[4]. The Ministry of Gender and Family promotion (MIGEPROF) indicates that approximately 17,000 teenage pregnancies, in 2017, were recorded among girls aged between 16-19 years[5]. The National Institute of Statistics of Rwanda (NISR) in its gender statistics report, highlights the birth rate among adolescent girls aged 15 to 19 years being on increase from 6.1% in 2005 to 7.3% in 2015, in the last decade.[6]

It is well known that teen pregnancy leads to health consequences such as pregnancy related illness, high infant mortality rate, low birth weight babies, maternal mortality and exposure to sexually transmitted diseases[7]. Teen pregnancy significantly contributes to high maternal and child mortality, and cycles of ill-health and poverty[8]. Pregnancy and childbirth complications are the leading cause of death among adolescent girls aged 15–19 years globally, with low- and middle-income countries accounting for 99% of global maternal deaths of women aged 15–49 years.[9] Adolescent mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20–24 years.[10] Additionally, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to maternal mortality, morbidity, and lasting health problems.[11] The United Nations Population Fund (UNFPA), emphasizes the burden of pregnancies among adolescent girls as a global concern as they do not only violate the rights of girls, with life-threatening consequences in terms of sexual and reproductive health, but also pose high development costs for communities, particularly in perpetuating the cycle of poverty[12]. Whatever the origin, teenage pregnancy is a health issue and a cause for concern. Considering its consequences, teenage pregnancy is a problem for the entire community.

At global and regional levels, initiatives have been taken, guidelines developed[13], programmes designed and implemented in the area of teen pregnancy prevention[14,15]. At local level, the Government of Rwanda has not been left behind. It has established laws[16,17,18], ministerial orders[19], ministerial instructions[20], policies and strategies to address the concern of teen pregnancy in the country [21,22]. Despite the efforts invested in addressing the teen pregnancy, there seem to be persistent challenges to achieve expected results.

Based on the context, the following questions need answers to better understand the issue:

(i) Are there barriers affecting teen pregnancy prevention in Rwanda?
(ii) If yes, what are they?
(iii) What could be done better to improve teen pregnancy prevention?

It is from the above questions that Rwanda Network of People Living with HIV (RRP+) in collaboration with the Rwanda Civil Society Platform (RCSP), conducted an assessment to understand the barriers that might be affecting expected results in terms of teen pregnancy prevention. This will enlighten the Government and its partners, how to tailor effective strategies and interventions to reduce pregnancies among teenagers and related consequences in Rwanda.

1.2. Objectives

1.2.1. Main objective

The main objective of this exercise is to assess various barriers affecting the prevention of pregnancies among teenagers in Rwanda.

1.2.2. Specific objectives

The specific objectives of the assessment include:

1. Identify barriers affecting teen pregnancy prevention at policy, legal and strategic planning levels;
2. Identify barriers affecting teen pregnancy prevention interventions at implementation level;
3. Identify barriers hindering the implementation of recommendations from various assessments and studies.

II. METHODOLOGY

2.1. Assessment Design and Techniques

This assessment consists of a descriptive design to understand the barriers that affect the prevention of pregnancies among teenagers in Rwanda. A qualitative methodology was used in this assessment. In order to collect relevant information, the following techniques were used:

2.1.1. Desk review

The review focused on existing resources including various reports, guidelines, policy documents, laws, and planning documents related to adolescent sexual and reproductive health in general and teen pregnancy prevention in particular.

2.1.2. Interviews with duty bearers

Interviews targeted key informants, at national and district levels. They were selected based on their area of work. At national level, the assessment included mainly Government Institutions, and Civil Society Organizations (CSOs) intervening in the area of sexual and reproductive health. The key informants were contacted and appointments were made to meet the interviewers. At district level, information was collected from health, education, and governance and gender units. Prior to data collection, a letter from RCSP and RRP+ was sent to the District to seek for authorization to meet the identified informants. Appointments were scheduled to meet each one of the key informants. The duration of interview was between 45 minutes and 1 hour.

2.1.3. Interviews with right holders

These interviews were conducted with selected teen mothers to get insights on their experiences and views on teen pregnancy prevention strategies as right holders. Teen mothers were aged between 18 and 20 years regardless of the age at their first pregnancy. Eight teen mothers per district were identified and invited by RRP+ field officers in their respective districts. Interviews with teen mothers were convened in a conducive and confidential place to ensure privacy following the provision of informed consent. In total 40 interviews with teen mothers were conducted.

2.2. District Selection

The assessment was conducted in four provinces and the City of Kigali. In a bid to have an overall picture across the country, one district with the highest prevalence of teen pregnancies was selected in each province and City of Kigali.

No	Province	District	Proportion of U20 pregnancies, 2018-2019
1	East	Gatsibo	12.0%
2	West	Nyabihu[1]	7.5%
3	North	Rulindo	8.7%
4	South	Nyanza	7.3%
5	City of Kigali	Kicukiro	5.7%

Source: *Rwanda Biomedical Center (2019). Annual Report for Maternal, Child and Community Health Division (2018-2019).*

2.3. Data collection and management

Prior to data collection activities, a one-day training was organized for interviewers to familiarize with interview guides. All interviews were conducted one-on-one, from the 11th to 15th June 2020. Field notes were used to record the information. All field notes were compiled per categories of key informants and summarized for analysis and interpretation.

2.4. Limitations of the assessment

During the course of this assessment, a number of limitations were encountered. As a result of time and budget constraints, the assessment was conducted in five districts. However, the assessment sampled one district in each province and the City of Kigali, to ensure representation.

In addition, the views of teen mothers' parents and healthcare providers would have been a valuable contribution for this assessment. However, it is important to note that some key informants from national and district levels indirectly provided their views as parents and people working with health facilities. The assessment was broad and could not also assess teenage pregnancy among specific populations, for instance PLHIV

Due to the sensitive nature of this topic, teen mothers could feel uncomfortable to discuss freely their experiences with a strange person. The assurance of confidentiality at the beginning and the privacy provided during the interview, both helped mitigate this challenge.

[1] *Nyabihu District replaced Rubavu district that was the second most prevalent district and with almost the same prevalence (7.6% in Rubavu and 7.5% in Nyabihu) because Rubavu District was put under lockdown during data collection period in the context of COVID-19 prevention.*

III. FINDINGS

The assessment intended to identify barriers affecting the prevention of teen pregnancies. As described in the previous section, in order to fully understand the potential barriers in teen pregnancies. This section presents and discusses the findings from desk review and conducted interviews.

3.1. Desk review

The desk review focused on existing national policies, legal frameworks, strategic plans as well as research reports identified as informative to the exercise.

3.1.1. Policy and legal framework

Rwanda has a documented commitment to gender and adolescent health issues. Different policies and laws have been developed. A part from identified gaps in policies/strategies and laws, in relation to adolescent sexual and reproductive health and rights, the implementation faces challenges. Below are key policies and laws reviewed:

Table 1: List of key policies and laws assessed

SN	Policy documents	Purpose in relation to teen pregnancy prevention
Policies		
1	National Reproductive Maternal, Newborn, Child and Adolescent Health (2018)	The integrated policy has the vision of achieving the highest attainable standard of health across the life course for all women, male and female children and adolescents in Rwanda.
2	Family Planning Policy (2012)	This policy was intended to increase the use of FP by Rwandan women of reproductive age group including adolescents from 15years to limit teenager pregnancies.
3	School Health Policy 2014	The SH policy aims to facilitate the optimum development of learners from pre-primary to secondary, by developing schools as supportive environments for health including sexual and reproductive health
4	National Youth Policy 2015	The policy aims at achieving a Health, Aptitude/Attitude, Patriotism, Productivity, and Innovation- Generation
Laws		
6	Law N° 21/05/2016 of 20/05/2016 relating to human reproductive health	The law determines obligations at different levels and services to be provided to citizens including adolescents

7	Law No 49/2012 of 22/01/2013 establishing medical professional liability	This Law establishes medical professional liability insurance and Committees for Conciliation and Compensation for health risks
9	Law No.54/2011 of 14/12/2011 relating to the rights and protection of the child.	The law targets people under the age of 18 years, this includes a big proportion of adolescents
10	Ministerial order N°002/MOH/2019 of 08/04/2019 determining conditions to be satisfied for a medical doctor to perform an abortion	This Order determines conditions to be satisfied for a medical doctor to perform an abortion. Beneficiaries include also adolescents below 18 years old.

3.1.1.1. Review of Policies

a. National Reproductive Maternal, Newborn, Child and Adolescent Health Policy (2018)

This policy was built on the previous adolescent sexual and reproductive health and rights (SRH & R) policy that was in use from 2011 to 2015. It recognizes the failure to fully implement strategic actions due to the following reasons:

i. Lack of oversight and ownership of this multi-sectoral Programme covering issues of health, education, gender, youth and rights;
ii. Insufficient capacity in the MoH and high turnover of staff working on ASRH & R; infrequent meetings and variable attendance at the ASRH & R Technical Working Group;
iii. Legal constraints to adolescents accessing SRH services and commodities;
iv. Religious, parental and cultural attitudes towards ASRH & R; and sustainability of stand-alone "youth-friendly "centers. (SRH & R, Page 25)

Although the current policy has been strengthened, ideally before the development of the new policy integrating maternal, new born, child and adolescent health in one policy, an assessment of the SRH & R policy would have better informed the current policy. For example, adolescent friendly services were clearly stated in the SRH & R policy. However, this aspect lacks the emphasis it deserves in the current integrated policy, yet the implementation of adolescent friendly services needs to be strengthened. The lack of emphasis on ASRH may cause teen pregnancy to be overlooked and absorbed by other routine areas of intervention.

Despite the establishment of youth corners at health centers, the functionality of youth corners is not well known. Some of health facilities have been provided with TV screens to be installed in their waiting rooms but no educational material such as CDs and videos were developed.

b. Family Planning Policy

The policy considers adolescents as an integral part of the document; it targeted people from 15 years old, girls and boys. It also notes the need to prevent adolescent pregnancy. The policy recognizes that ensuring sufficient focus and expansion of adolescent sexual and reproductive health (ASRH) programs and ensure that they are provided in a youth-friendly manner" should be a priority among first seven priorities across the four objectives of the policy (Page 16). In line with promoting the use of family programs, MoH through the policy committed to:

- Create youth friendly conditions within the health facilities but also extend youth friendly services including adolescent to youth friendly centers with other ministries that have youth in their responsibilities (Page 17).
- Develop strategies that promote positive attitudes among community members about the use of contraception by youth- As per national youth policy, youth includes a big part of the adolescent since its definition brings in adolescents from 16 years [23]. This means, adolescent from 16 years could be accessing contraceptive methods. However, family planning methods in the community is perceived as meant for married couples and interpreted as promiscuous adolescents and young unmarried adults seeking family planning services.
- Promote a safe and supportive environment for improved adolescent health and FP use among youth through sustained advocacy to cabinet and legislators (Page 17).

The Policy sounds good in terms of target group (from 15-49 years old), however, the policy seems not to be consistent with the human reproductive law in its Article 7, where only those above the age of 18 years old have the right to independently decide on human reproductive health issues. Therefore, it implies that those under 18 years old can only access the reproductive health services with consent of parents or legal guardian. This is legal barrier to teen girls under 18 years old to fully access family planning services who are in their reproductive age.

c. Youth Policy

The policy recognizes sexual and reproductive health and drug abuse related issues as the main health problems that affect Youth in Rwanda today. It is also in agreement with the fact insufficient

information on SRH leads to a number of challenges including population growth. However, the policy does not stipulate concrete strategies and actions to address sexual and reproductive health challenges and teen pregnancy in particular.

d. School Health Policy

The Ministry of Education developed its first school health policy in 2014, and still valid today. One of the recommended policy actions under SRH and GBV issues was to combat teen pregnancies through sensitization of youth on early pregnancy and reproduction health choices. The Ministry of Education committed in the policy to establish a follow-up system, to ensure that young women who dropped out of school due to pregnancy return to complete their studies (See Page 41).

Although, this is clearly stated in the policy, there is no follow-up system established following a period spanning for more than 6 years of policy implementation. During the assessment, we could also not spot any specific support system in case these young women return to schools. A number of questions remain unanswered: Who cares for the baby once the mother goes back to school? Are parents willing to pay for school fees and other ancillaries for schooling?
It is critical for the new policy under development to take cognizance of these challenges and provides a clear follow-up framework to ensure teen mothers are taken back to school with a specific support systems in place.
Comprehensive sexual education has been integrated in different subjects, yet learning is driven by assessment. The fact that such topics are not formally assessed, teachers cannot ascertain whether SRH outcomes were achieved. It is therefore hypothetical to confirm whether kids are imparted with the right SRH knowledge.

Comprehensive Sexuality Education (CSE) is integrated in five subjects, two in Primary schools (Science and Elementary Technology, and Social Studies) and three in Secondary Schools namely; Biology and Health Sciences, General Studies and Communication Skills including History and Citizenship. While the primary intent of that integration appear to be a positive move in delivering SRH knowledge, this approach tends to divert the required SRH focus during the delivery, hence affect negatively the expected outcome of this intervention.

3.1.1.2. Review of Laws and Ministerial Orders

(i) Law N° 21/05/2016 of 20/05/2016 relating to Human Reproductive Health

The above law was promulgated in 2016 and stipulates the obligations of parents and Government with regard to human reproductive health.

Parents' Obligations

Under article 14, parents have the following obligations as stipulated: "*Every biological parent or guardian has the duty to discuss with the children about human reproductive health*".

By definition, human reproductive health, in the Article 2, refers to a state of human physical, mental and social well-being in all matters relating to the reproductive system and its functions and processes. By law, a parent who does not discuss with his/her children about human reproductive health does not fulfil parental obligations towards their children. Enacting a law emphasizing the duty of parents vis-à-vis reproductive health is encouraging. However, there is huge gap in the implementation of this legal provision. Data from a baseline survey on school-based comprehensive sexuality education reveals that 62% of children (boys and girls) aged between 10-19 years old have never discussed with their father's sexuality related topics against 50% who have never discussed the topic with their mothers. It was also evident that the lack of sexual and reproduction health education is one of the barriers for teen pregnancy prevention[24]. Although the law requires parents to educate their children on reproductive health, there remains a critical challenge on the implementation of the provisions of this law.

Apart from existing cultural and religious barriers affecting sexuality related discussions between old and young Rwandans, it is worthwhile to note other important factors behind the limited SRH education of parents to their children. These factors include parents' limited awareness of the above legal provisions, limited knowledge and skills on SRH, challenge with the delivery approach according to age-specific categories of children, and most importantly the lack of educational materials on SRH.

Government's obligations

The law stipulates that: "*The Ministry in charge of health has the authority to monitor human reproductive health-related activities". In addition, "A Prime Minister's Order determines the role of other institutions in activities related to human reproductive health.*"
According to the Article 19: "the educational curricula of different categories of schools and literacy centers must provide courses on human reproductive health. An Order of the Minister in charge of education determines modalities for the implementation of the provisions of this article". To the best

of our knowledge, both ministerial orders are not yet published. Therefore, the legal provisions of the above law can hardly be implemented since the enforcing orders are not in place.

(ii) Law No 49/2012 of 22/01/2013 establishing Medical Professional Liability Insurance

Article 3 of the Law No 49/2012 of 22/01/2013 on medical professional liability insurance provides for the right to dignity and privacy. In the context of access to sexual and reproductive health services, this provision sounds good. In addition, the article 4 prohibits any form of discrimination in terms of access to consultation and healthcare services. However, the same law in its article 11 does not allow children (by definition those under 18 years old) to seek healthcare services without the prior consent of their parents or legal guardians.
With regard to this law, access to sexual and reproductive health services including family planning becomes difficult for this target population.

(iii) Ministerial order N°002/MOH/2019 of 08/04/2019 determining conditions to be satisfied for a medical doctor to perform an abortion

The ministerial order provides legal grounds for abortion and this includes pregnant children under 18 years old. However, the acceptability of this order by healthcare providers and community needs further assessment. It is important to highlight that, teenagers face a great deal in disclosing their pregnancy status to parents for fear of rejection, associated stigma and the frustration that is associated with having a pregnancy out of normal societal norms. Teenagers strive to hide this information from parents. Consequently, the pregnancy is noticed after the prescribed abortion timeline (before 22 weeks). Yet the provisions of this ministerial order gives only parents or legal guardians the power to request for an abortion. Therefore, given the dynamics around teen pregnancy within the community, the implementation of this provision remains challenging from a practical perspective.

3.1.2. National Strategic Plans

The Ministry of Health developed a number of strategic plans, each with a component on adolescent sexual and reproductive health. However, our analysis show gaps in the operationalization of the developed plans. A limited focus on ASRH was noted as a critical challenge in addressing the teen

pregnancies. Annual operational plans at national and district level would facilitate the required implementation.

Table 2: Reviewed Strategic Plans

SN	Plans	Strategies
1	Health Sector strategic Plan 2018-2024	• Increase the demand for ASRH services by increasing the access to services for Adolescent and youth • Expand the coverage of ASRH services (e.g. increasing youth-friendly centers and corners in appropriate settings)
2	Family planning and adolescent sexual reproductive health strategic plan 2018-2024	• Establish mechanisms to ensure and maintain FP/ASRH data quality at all levels • Strengthen and/or design and implement youth-friendly multi-channel interventions to reach various segments of the adolescent population, including youth with disabilities and other vulnerable groups • Create opportunities for inclusion and participation of adolescents and youth designing, validating and monitoring ASRH program and services. **Illustrative activities:** • Restructure and scale up in and out of school ASRH clubs and ensure ASRH messages are well delivered until the youth feels more comfortable to seek services from CHWs
	FP/ASRH strategic plan (page 32) highlights annual operating plans and recommends that a multi-year FP/ASRH strategic plan should guide the development of annual operating plans and budgets at both national and district level.	

Prior to the current Reproductive Maternal, Newborn, Child and Adolescent Health Policy (RMNCAH, 2018), there was a standalone adolescent sexual and reproductive health and rights policy. Its integration within RMNCAH policy presents challenges during the implementation. There is a tendency to focus on traditionally and widely known areas. Consequently, ASRH programs are overlooked and interventions diluted. There is a tendency of having very good strategic plans without implementing annual operational plans specifically addressing the teen pregnancy. During our review, we noted the availability of well-formulated strategies that are not implemented. Hence, the absence of operational plans lead to the lack of assessment and mid-term review that could address the ASRH areas of interventions.

3.1.3. Review of Studies and assessments conducted in Rwanda

In order to understand the phenomenon of teen pregnancy in Rwanda, various studies and assessments were conducted during the last 4 years. The related findings and recommendations were disseminated, mainly through reports. However, it is not clear whether those findings and

recommendations have reached all the stakeholders, including the Government, Civil Society Organizations, Parents and teenagers.

This assessment found that, the seven studies and assessments analyzed were conducted in 27 Districts over the last 4 years. This emphasizes the need for a national and comprehensive survey to have the picture of the whole country on teen pregnancy.

Table 3: Reviewed studies and assessments, conducted in Rwanda

SN	Research Title	Geographic Coverage	Key Findings	Key Recommendations
1	*KAP: Parents' Comprehensive Sexuality Education in secondary schools in Rwanda, 2019 by HDI*	10 Districts	Parents understand the importance of CSE, but are not often engaging in conversations with their children around sexuality-related issues.	• Use existing platforms to educate both parents and children • Develop and disseminate comprehensive guide for teachers • Involve youth in the development and dissemination processes
2	*Participatory Action Research on attitudes, perceptions and needs towards teenage pregnancy, 2019 by RWAMREC*	2 Districts	• Teenage pregnancy is perceived as a sign of parental failure. • Limited knowledge about SRH • Misconception about the use of contraceptive methods • Lack of dialogue with parents	• Conduct media campaigns to raise awareness of communities • Involve Animatrices to raise awareness on SRH at school • Ensure SRHR is assigned sufficient space in the community meetings and structures
3	*KAP: GBV root causes and IOSC services delivery, 2019 by MIGEPROF*	9 Districts	• People have limited knowledge on GBV law and its provisions • Culture of silence, families prefer to resolve GBV cases within and among themselves. • Limited reporting	• Effectively dealing with perpetrators • A multi-pronged approach involving different stakeholders including youth • Facilitate access to relevant information and contraceptive methods
4	*Readiness of the community to address teenage pregnancy in Rwanda, 2018 by HAGURUKA*	7 Districts	• Teen mothers are mistreated, insulted and abused by parents, neighbors, peers, religious and local leaders, and community because of pregnancy.	• Development of prevention measures, such as sexual and reproductive health (SRH) teaching from younger age by various institutions (schools, churches, NGOs…) to sensitize the entire community.
5	*Rapid assessment baseline on the status and needs of teen mothers, 2018 by Reseau des Femmes Oeuvrant pour le Developement Rural*	23 Districts	• Parents are ignorant about child rights; • Poor knowledge of girls about SRH; • Culture of silence and impunity • Low commitment among community leaders to prevent and respond to teen pregnancies	• Train parents and local leaders on child rights, SGBV, laws, and their responsibilities; • Engage with FBO leaders to support initiatives against teen pregnancies; • Carry out comprehensive research on situation of teen pregnancies in Rwanda for appropriate response • Invest more efforts in data collection and monitoring

6	*Baseline Study for the School–Based Comprehensive Sexuality Education Programme in Rwanda, 2017 by REB*	16 Districts	• 62% of teens have never discussed sexuality issues with their fathers and 50% with their mothers • Some teachers who do not feel comfortable to teach sexuality-related topics	• Several other groups need to be reached in order to create an enabling environment for the implementation of the learning from the School-Based CSE. • Parents should also receive CSE.
7	*Advocating for girls' rights social protection through fighting against early and unwanted pregnancies in Rwanda, 2016 by CLADHO*	10 Districts	• Sexual education is not given enough time and attention, as it is integrated in other subjects; • Girls get most of the information on sexuality from their peers — who are also not well informed — and social media networks.	• Invest in efforts to improve data on monitoring and evaluation. • Involve teenagers in campaigns, discussions and debates on teen pregnancy; • Raise public awareness on human rights principles especially child rights

During this assessment, we met some of those institutions that conducted the assessments to appreciate the progress in the implementation of the formulated recommendations. However, majority reported the lack of follow up of the implementation of the recommendations. There is a challenge in translating the various recommendations in tangible actionable activities. They, in addition, reported the likely reasons behind this poor follow up to include lack of strategic dissemination, less attention from stakeholders, and integration of ASRH; yet it should be considered and treated as public health threats given the negative impact it has on future generation of the country and the burden it represents for the teenagers and their families.

While we noted a positive trend in the right direction towards teen pregnancy research, conducted studies are still very few to provide a full understanding of the teen pregnancy phenomenon. The geographical coverage lacks national representation and the topics covered are not comprehensive enough to provide a thorough understanding of teen pregnancy phenomenon and associated characteristics.

"I appreciate the work being done by civil society organizations and Government by conducting the assessments to understand this problem. We have good policies and laws. The studies draw very good recommendations, but the implementation of these is still an issue. The translation of those recommendations into actions is where we have problems. There is lack of follow up. It seems people are not much concerned with this problem. There is lack of accountability ("Iyo abangavu batewe inda, ni nde ubibazwa? Mwalimu, ababyeyi cyangwa Abayobozi b'idini? Abayobozi b'inzego z'ibanze? No one, expect few perpetrators if reported.). These recommendations should be followed up; they should be stated in a clear statement that can be easily translated into action. The way we disseminate our findings also has a gap. Reports and workshops are not enough. Let's approach those whom we want to implement those recommendations. We need to be more strategic." ***A Human Rights activist and researcher on women and children rights revealed.***

3.2. Interviews

3.2.1. Respondents' Profile

i. **Duty bearers:** Among the duty bearers, out of 40 key informants that the assessment was targeting, 35 participated, including 3 people from Government institutions (Ministry of Health, Ministry of Youth and Culture, and Ministry of Education), 14 from CSOs, 16 District officials, 1 from UN Agency and 1 religious leader (See Annex 4).

ii. **Teen Mothers**: The Table 1 below presents socio-demographic characteristics of the 40 teen mothers who informed the assessment. The mean age of teen mothers at their first pregnancy was 17 years old. The majority (39/40) of them had only one pregnancy. With regards to their occupation at the time of their first pregnancy, it was found that 18/40 were in school. More than a half (23/40) of teen mothers have completed primary education. Although the sample is very small, this finding is comparable to the national data suggesting that a lower level of education is more likely to lead to teenager pregnancy.[24] At the time of first pregnancy, the data showed that a half of teen mothers were classified into the Ubudehe II category. The large majority (35/40) of them reported, having been impregnated by their peers (boyfriends).

Table 4: Teen Mothers' Profile

Variables	Frequency
Teen Mother's age (Mean) at first pregnancy in years	17
Parity (Mean)	1
Occupation at the time of pregnancy	
None	13
Casual work	2
Housemaid	6
Security Agent	1
Student & Vocational	18
Completed education level at the time of pregnancy	
None	6
Primary	23
Ordinary (S3)	11
Ubudehe category at the time of pregnancy	
Ubudehe 1	8
Ubudehe 2	20
Ubudehe 3	12
Relationship with the Perpetrator	
Peer & Boy friend	35
Boss	1
Educator	1
Sugar Daddy*	2
Unknown (Rape)	1

* Respondents referred to an older man who lavishes gifts on them in return for their sexual favours.

3.2.2. Main factors of teen pregnancies

Both right holders and duty bearers were asked to state what might be the main causes and factors associated with pregnancies among teenagers. The teenagers were particularly requested to share their own experience. The factors mentioned and explained were categorised into four categories: individual, family, socio-cultural and community factors.

3.2.2.1. Individual factors

The majority of the teenagers interviewed reported to have poor knowledge about sexual reproductive health. The respondents also highlighted the need for many teenagers of having more than what their families can afford. This makes them vulnerable as they exchange sex for gifts, money and promises. In addition, most of teenagers have unprotected sex, they do not use condom, as they confessed. The main views of respondents are illustrated in the quotations below:

"I went to visit my boyfriend not far from home; I did not know very well the time I can get pregnant… I was told by my friends that having sex could clean my face because I had many spots in the face – unfortunately, nothing changes, I still have them. This belief also pushed me to have sex with that boyfriend." ***A Teen Mother in Kigali City sharing her experience on how she got pregnant.***

"According to me, the lack of information on Sexual Reproductive Health is the main cause of teen pregnancy and we can't expect something positive if this is not well tackled. The correct information is the main tool for them to make an informed decision. Our adolescents do not know how to behave as far as sexuality is concerned, plus the pressure of their peers to taste sex, plus their physiological changes that we all know. They are pushed to do sex but they need to be well equipped to make a right decision. They need to know when they can get pregnant and other consequences of unprotected sex." ***An SRH Specialist reported.***

"Our adolescent girls want to live beyond their means and their families are not able to provide all they need. There are men who know that and who know how to play that card. They give gifts, money and other promises to those girls in exchange of sex. In that situation, it is the man who has the power to decide how and when the sex will be done… Though I don't remember well the statistics, but very few teenagers use condom; the confirmation is those pregnancies." ***A Human Rights activist revealed.***

3.2.2.2. Family factors

As per the quotations below, both key informants and teen mothers revealed that sexual education at home is still an issue. The lack of sexual education in family has been pointed out as a main cause of teen pregnancies. The teen mothers confessed that the family situation, especially poverty and conflicts are the main causes of pregnancies among teenagers. The dislocation within the family leads to poor or little guidance to children. This creates an emotional vacuum that an outsider may take advantage of children's vulnerability and pregnancy may occur[25], [26]. Some parents are accused to keep themselves busy such that they do not have time to discuss sexuality with their children. The irresponsibility of parents was mentioned as a main factor of teen pregnancies; parents' time focused on work and livelihood activities. The majority of duty bearers and right holders interviewed reported that few parents discuss sexuality and prevention of pregnancies. However, they reported scepticism of the validity and sufficiency of information they provide.

"When my father died, my mother got married to another man. The new man did not like me. One day, he kicked me out, and my mother could not do anything to bring me back home. I went to live with my friend who sometimes practiced sex work. An unknown man came, asked me to have sex with him in exchange of money and impregnated me. The main cause of my pregnancy is the family issues." ***A Teen Mother in Kigali City reported***.

"Nowadays, parents have no time for their children. This parents' attitude makes me wonder if they really have knowledge about sexual and reproductive health to share with their children. That important aspect of education has been left in the hands of teachers at school while some teachers are also among the perpetrators. On this, there is a need to assess their knowledge and methodology they use to teach those subjects. Do they know what to say and how say it? … Sexuality is a "taboo", it is demonised such that even parents who try to talk about sexuality do it superficially, as if they are touching in the fire or talking about something prohibited." ***A Religious Leader in City of Kigali reported***

"I cannot say that all parents do not discuss sexuality with their children; there are some parents who are willing to help their children and dear to teach and discuss this topic with their children. However, I am not sure of the accuracy and validity of that information because some parents might have no correct knowledge of sexual and reproductive health. For example, there is one of my neighbours who has been teaching her teen girl that having sex during menstruation period is very risky because you can directly get pregnant… Parents need education on this too: what can be told? How and to children of which age? " ***An SRH Specialist reported.***

The results above are in accordance with the findings published by Marshall E. P and Jones N. (2012), who reported that in many cultures, parents provide little sexual education, as they "feel uncomfortable to give sexual training to their children and teenagers". The fact that many parents never received adequate information regarding sexuality and reproduction themselves makes them vulnerable to teach their children, they added.

3.2.2.3. Socio-cultural factors

Some key informants reported the Rwandan culture being one of the contributing factors despite available laws and policies. Some Rwandans hold the belief that having sex with teenagers is an acceptable practice. Some people underestimate the problem of teen pregnancy. Hence, the reason some families tend to sort this out amicably once it ensues.

"Despite the good laws and policies that are in place, there are some people who still believe in sayings for instance "Ikiziranyenzi kivukana inda" which means that it is normal for a girl to be pregnant. It is as if girls are born to get pregnant." ***A Religious Leader in City of Kigali reported***.

"In our culture, talking about sexuality especially with your children does not sound good (laughing)! On this, religious beliefs become a great barrier. Sexuality is somehow demonised. This is a topic that remains a taboo until the consequences fall to the victims. Many men think that it is the responsibility of women to tell this to their girls and women, according to our culture, do not talk about sexuality. Finally, no one will tell this to the teen girl. You understand what will happen after: the girl will get pregnant as accident because no one told or taught her the traffic laws (if I can say so). " ***A leader in Rulindo District expressed.***

"I asked my parents why they did not tell me about this (when and how a girl gets pregnant) and told me that the culture does not allow talking about "ibyo bishitani"! They believe that talking about sexuality it is the same as promoting it. They added that I should have asked this to my teachers." ***A teen mother in Nyanza District shared.***

3.2.2.4. Community factors

A good number of our respondents reported that teen girls who are not in boarding schools are more likely to be impregnated because they are somehow exposed to temptations. The social media was also reported as one of the community factors behind teen pregnancies. Below are some excerpts from respondents:

"When I look back and try to analyse why I was impregnated I found that the fact that I was passing every morning and evening in the commercial centre, it exposed me to different boys including the one who impregnated me. I had access to mobile phone and they could call me anytime they wanted. Slowly by slowly I found myself sleeping with one of them…. If was in boarding school, I think I would have not been impregnated because there are authorities who are always following up what you do and you can get punished if they find you talking with a boy in private places. It was very easy for me to lie to my parents and they had no much time to monitor all my movements… When I will get a chance to go back to school, I will do my best to find a school with boarding section." ***A Teen mother in City of Kigali reported.***

"According to me, though I did not do a research on this, but I think that student girls who are not staying at school are more likely to be attracted in sexual affairs that can result into pregnancy than those who are in boarding schools. They are somehow left alone while they still need regular guidance and companion of a grown up person. Can you imagine a girl of 15 years old travelling alone around 5 km every day? It is obvious that she will be approached by different people with different intentions." ***A leader in Nyabihu District said.***

"Those social media, especially Facebook, WhatsApp and YouTube can be also among the factors of pregnancies among our teenagers…. Our children like them (social media) a lot and the information they provide are not always correct. In addition, our children tend to imitate the so-called stars who are always played there while most of them are not giving a good example." ***A leader in Rulindo District reported.***

"I went to visit my boyfriend who had a smartphone. We watched together a pornography movie… It was my first time to watch such movie. I cannot lie to you; I felt too hot and had directly sex with him… I think we do not understand what we call vision, technology and social media because what is played there is not always useful and helpful." ***A teen Mother in Kigali City revealed.***

3.2.3. Respondents' views on existing strategies to prevent teen pregnancies

The respondents discussed the strategies and interventions in place to prevent teen pregnancies. Those strategies include the enactment of laws; development of policies, strategic plans, advocacy strategies and other activities implemented with the aim to prevent pregnancies among teens. This was an opportunity for respondents to critique and appreciate them.

The majority of interviewed duty bearers appreciated the existence of laws, policies and strategic plans to address the issue of teen pregnancies. However, they highlighted some gaps and barriers such as poor coordination of interventions, limited budget and poor integration of actions.

3.2.3.1. Awareness on the existing strategies for teen pregnancy prevention

During the interviews, interviewed duty bearers confirmed their awareness on strategies to prevent teen pregnancies including laws, policies and strategic plans. However, most of teen mothers reported that they heard about those strategies, although they do not know what they entail as far as the content therein is concerned. Below are some excerpts from respondents:

"I know that the Government developed different strategies to prevent teen pregnancies; they are well written but their implementation needs to be improved. Let me give you an example, the provision of Family planning to adolescent girls. There are some questions that we need to clarify: Are there healthcare providers dedicated to the provision of such services? Is there any special time and space for adolescents? Do they have adequate educational materials? How is the attitude of those providers in the context of Rwandan culture? All these may hinder the implementation of those strategies." ***An SRH Specialist working with UN Agency in Rwanda reported.***

"When I was in school I heard about those laws but I don't know very well their content. For example I would like to understand more about the laws on family planning and abortion, but I don't know where I can find those documents, if they are in Kinyarwanda." ***A teen Mother in Kigali City stated.***

"The laws and policies are known by very few people. If the parents knew the laws and policies to prevent teen pregnancies, they should have educated their children on sexuality and reproductive health and should have not kept silence when their child is abused." ***A Human Rights activist said.***

3.2.3.2. Gaps in the existing strategies for teen pregnancies prevention

With regards to gaps within the laws or policies at the face value; or in their implementation, most of the key informants outlined critical areas which need special attention such that the good written wishes are translated into tangible actions with tangible impact and results. The issues of coordination of interventions, funding and integration were consistently and frequently mentioned by the key informants. Using the following quotes, apart from highlighting the gaps, the respondents suggested some recommendations to be taken into consideration for successful implementation of strategies to address the issue of teen pregnancies:

"If we really understand the issue of teen pregnancies, we need to put in place a strong coordination and monitoring mechanism. All stakeholders must be given a clear tasks and clear operating manuals. A strategic plan without a short-term operational plan cannot be successfully implemented. Allow me to talk about the budget that is allocated to related interventions: it is still low compared to the activities to be implemented. Another aspect to improve the implementation of good strategies in place is treating the issue of teen pregnancies as a special case; if it is integrated together with other interventions with promising results, it will be difficult to have results." ***A Religious leader advised.***

"Behaviour change is not a tick-tack action; it requires regular and consistent coordination, monitoring, timely reporting and close follow up. In addition, the beneficiaries should be involved and participate in the development of strategies and implementation of actions…. If the law give responsibility to parents to educate their children on sexual and reproductive health, there should be a framework to teach them to ensure they have a good understanding of the matter." ***An SRH Specialist working with UN Agency in Rwanda reported.***

"The laws are well structured; rights and how to deal with perpetrators are clear and reasonable… However, there are some issues to be addressed like decentralised dissemination of laws and policies to make sure beneficiaries know them… The funds allocated to prevention activities are like a drop in a sea. The issue is bigger than actions. However, I cannot say that nothing is being done, but this problem should not be treated in general; it should be taken as special because it is all about change of mentality." ***A Human Rights activist revealed.***

"We thank our Government for laws and policies to prevent teen pregnancies. We also get recommendations from various assessments like this. However, the budget to implement those activities are very small. This is a complex problem that requires more means. The support of District partners is unequally dispatched. There are some Districts with no partners working in that domain while there are other Districts with more than partner. This is a problem of the whole country. The support must be well coordinated to ensure countrywide coverage." ***A leader in Rulindo District strongly recommended.***

IV. DISCUSSION

The previous chapter highlights a number of barriers hindering teen pregnancy prevention. Under this chapter, identified barriers are discussed. Those barriers are at policy, law, community and individual levels.

4.1.1. Weak coordination of interventions

Various Government institutions have the adolescent health in their mandates. Within the Ministry of Health/RBC there are adolescent desks for HIV and MCCH. Teen pregnancy is also tackled within the SGBV context at MIGEPROF. Unfortunately, there is no coordination mechanism to ensure everyone is brought on board, each one knowing his/her role and responsibility during the implementation of various interventions. There are many good interventions, unfortunately they are scattered.

There is a need for strong coordination and monitoring mechanisms. Another typical example relates to the data reporting. The reported data through RHMIS are collected from ANC services. These numbers include married adolescent girls. This reporting system provides a proxy; and it does not provide the real magnitude of the problem. There is a need to develop a coordinated reporting system that provides accurate data analysis and appropriate interventions.

(i) Scattered and duplicated efforts

The assessment noted a wide section of well-intended stakeholders in the fight against teen pregnancy. However, there is a lack of strong coordination mechanism in place and some implementers duplicate efforts and do not complement each other such that a strong impact is felt in this fight to prevent teen pregnancy. A strong coordination mechanism is paramount to have a positive impact in the prevention of teen pregnancies. During the assessment, it was noted that some districts/ regions have many Government partners while other districts have no partner at all. A coordinated mechanism would be ideal to address such disparities.

(ii)Lack of collaborative approach among CSOs

The various actors involved in teen pregnancy prevention programs are well aware of the increase of numbers every year. However, when it comes to strategies to fight teen pregnancy mainly the use of modern contraceptives, even civil society organization diverge. This divergence of opinions

and lack of common vision act as a setback in addressing teen pregnancies. During the interview, some members of CSOs expressed their divergence in opinions and views vis-a-vis family planning service provision to teen girls. This raises red flags on the kind of advocacy approach that CSOs would undertake on an issue that they hold divergent views. CSOs are contributing a lot towards teen pregnancy prevention interventions. However, there is no sufficient joint mechanism that brings the organizations together during the various processes in addressing teen pregnancy from planning to implementation and experience sharing. A collaborative mechanism would enrich the CSOs and make an impactful contribution towards prevention of teen pregnancy.

4.1.2. Policy and law related barriers

(i) Gaps in laws and policies

During the review of key policy documents in relation to SRH, we noted some inconsistencies between the Human Reproductive Health law and Family Planning policy. The Policy targets all people aged from 15 to 49 years. However, the Human Reproductive Health law in its articles 7 and 10 stipulate that only those aged 18 years and above have the right to independently decide on matters related to human reproductive health. In addition, the Medical Professional Liability Insurance law in its article 11 states that *"the health professional who intends to provide healthcare services to a minor or an incapable person must endeavor to inform his/her parents or his/her representative or his/her guardian and obtain their prior consent."*

By interpretation of both laws, the teen girls under 18 years are considered as children and can only access reproductive health services with the consent of parent or legal guardian. This is a serious barrier for teen girls under 18 years old to access family planning services despite being in the age of reproduction.

The provision of HIV-AIDS services[28], including HIV counselling and testing and Voluntary Medical Male Circumcision, Anti-retroviral therapy, etc., considers people aged 15 years eligible to access the services without the consent of parent or legal guardian. Though HIV guidelines are in favor of adolescents under 18 years old, they are not consistent with the above-mentioned laws. It is high time to read with the right lenses the magnitude of teen pregnancies and give it the deserved attention.

(ii) Lack of implementing tools

The Government of Rwanda has developed and disseminated laws and policies related to sexual and reproductive health; however, such policies and laws lack implementing instruments for instance ministerial orders or instructions to facilitate their implementation. These instruments are key in defining and clarifying the roles of various stakeholders. The absence of clear roles and responsibilities creates ambiguity in implementation and a room for lack of accountability.

The typical example is that of the School Health Policy which needs a follow-up mechanism for the teen mothers who dropped out of school to ensure they are taken back to school, as stated in the same policy. Another live example is the Human Reproductive Law that lacks the Prime Minister's order highlighting the role and responsibilities of different institutions; and an order of the Minister of Education determining the modalities for the implementation.
In addition, the success of strategic plans implementation depends greatly on annual operational action plans with clear activities, targets, implementers, budgets which makes the implementation and monitoring easier. Critical gaps and weaknesses were noted; there are no well-defined indicators that allow to measure the impact.

(iii) Integration of policies and strategic plans

The integration of strategies is important especially when it comes to addressing complex and crosscutting issues. However, when incorporated, it might not draw special attention while dealing with critical issues. In the context of teen pregnancy prevention, it was found that, in 2018, the adolescent sexual and reproductive health and rights policy (ASRH) was integrated in the Reproductive Maternal, Newborn, Child and Adolescent Health Policy (RMNCAH). The ASRH strategic plan was further incorporated in family planning strategic plan. In both cases, ASRH is overshadowed by family planning, maternal and child related issues during implementation. The need for adolescent health and specifically the magnitude of teen pregnancy challenge is not well highlighted and given due attention as a result of this integration. It might further affect funding for the various interventions targeting the adolescents. The majority of the duty bearers underscored this type of integration as a barrier to the implementation of efforts to fight teen pregnancy because it makes difficult systematic monitoring of interventions and activities.

*"The issue of teen pregnancy in Rwanda should be treated with much attention. It is should not be integrated among other interventions. When interventions are integrated, it is very difficult to measure the achievements and know what is working and what is not. Integration of interventions is good for only problems under control." - **A Religious leader, Kigali.***

*"The integration of sexual reproductive health in different subjects at school is good but the evaluation of that knowledge remains unclear." **An SRH Specialist working with UN Agency reported.***

(iv) Dissemination of policies and laws

According to different participants, very few people have knowledge of the existence of policies, laws and strategic plans about prevention of teen pregnancies. Inappropriate dissemination of policies, laws and different research reports was identified as a barrier to the current limited knowledge for the community in general. It was noticed that people have limited information about existing policies and laws related to sexual and reproductive health. For example the law on abortion and obligations of parents to educate their children on sexual and reproductive health. Respondents were very critical on this issue and suggested a "strategic dissemination" approach of various documents to make sure majority of stakeholders are aware of the content of the existing laws and policies tackling sexual reproductive health and rights.

The WHO stipulates that the dissemination of laws and policies on sexual reproductive health and rights, if implemented for all, contributes to people's knowledge of what protects or damages their sexual health. The dissemination should therefore be done beyond the official publication in the national Gazettes. The Government should use a variety of channels including youth organizations, religious, community and other groups, and the media to increase public awareness.[27]

4.1.3. Barriers related to the ownership of health facilities

Despite the Government commitment and combined efforts to fight teen pregnancy, there are still barriers related to access to SRH services in the health system. During the interview, a key informant mentioned that *"the provision of sexual and reproductive services is a challenge in health facilities owned by faith-based organizations, mainly catholic church as they are against modern contraceptive methods."* A national study on family planning barriers in Rwanda, underlines barriers towards uptake among youth (including adolescents). The survey highlights

that that the whole package of Adolescent Sexual and Reproductive Health and Rights (ASRH & R) services including Family Planning is not available in all health facilities[29].

This can be also related to a big number of health facilities owned and operated by various faith-based organizations. Considering the ownership of health facilities, 30% of health facilities in Rwanda are faith-based, most of them being operated by Roman Catholic Church[30]. This church has a clear stand on sexual and reproductive health services offered by health facilities under their custody. Though around 700 secondary health posts have been established, ownership of the health facilities seems to be one of the barriers affecting teen pregnancy prevention. To the extreme, catholic-based health facilities can only refer the FP service seekers to the secondary health post. However, the respondents strongly recommend equipping those health posts with qualified personnel and infrastructure (medical equipment) to gain the trust of the community.
In a study conducted by Schwandt et al. on Family planning in Rwanda, the Roman Catholic Church-supported health facilities were mentioned among the barriers faced by the Rwandan family planning policy[31] which constitutes a barrier to the prevention of pregnancies among teen.

4.1.4. One-way focus

There are many interventions. However, such interventions target teen girls. Needless to say, several partners tend to ignore teen boys. Yet, reference to CLADHO's assessment, around 49% of girls were impregnated by their peers (of the same age). Teen girls are victims as a matter of fact. Nonetheless, all the wonderful interventions devised to address the teen pregnancy must be re-thought about to include their male peers. It is high time for various stakeholders to direct their attention to young boys equally. Inclusive interventions are likely to impact positively the prevention of teen pregnancy, rather than unilaterally focusing of teen girls.

4.1.5. Barriers related to the community

(i) Lack of comprehensive knowledge on SRHR

The present assessment and other studies and assessments above-presented showed without shadow of doubt that both parents and teenagers have limited and poor knowledge on sexual and reproductive health and rights[28,32,4,33,34,35,24]. The knowledge they have is a mixture of rumors perpetuated by uninformed and ill-intended individuals, as presented in a systematic review

conducted in Rwanda and Ethiopia. The review revealed that "adolescent girls' needs for SRH information remain largely unmet; they generally receive only partial (and often inaccurate) knowledge based on information they get from their peers. Misinformation is particularly common in rural settings where girls are less likely to be in school and where parents usually have lower levels of education… others have superficial knowledge from teachers."[35] Another study found that knowledge about sexual and reproductive health issues remains low and most adolescents access such information from their peers, thus resulting to various misconceptions.[32]

(ii) Lack of discussion between parents and children on SRH

Generally, particularly in the Rwandan context a family unit is perceived as the main, stable institution that instill a set of values in children. The family is expected to be one of credible sources of information on sexual and reproductive health. However, parents in addition to their limited knowledge in SRH are not comfortable to discuss topics related to sexuality with their children, despite having the obligation to do so as provided for by the human reproductive law: *"parents are responsible to educate their children on sexual and reproductive health"*. Parents tend to adhere to conservative social norms that largely preclude parent–child communication about SRH matters. It is also important to note that some individuals hold mythical knowledge on SRH and others have superficial knowledge from teachers.

(iii) Cultural and religious beliefs

Religion and culture form a negative power when it comes to the prevention of teen pregnancies. Sexuality is treated as a taboo by both the religion and Rwandan culture. On one hand, some religions consider some prevention strategies as being in contradiction with their fundamental beliefs, hence classified as sin. The common and typical examples are condom use and family planning.

On the other hand, the Rwandan culture does not promote sexual education, especially at home. Influenced by cultural and religious, some Rwandans have negative attitudes towards the use of family planning methods among unmarried women. These challenges are exacerbated by the myth around sexuality held by the majority of Rwandan community and the limited knowledge on SRH.

(iv) Social media influence

The film industry is taking shape in Rwanda. Unfortunately, majority film actresses in Rwanda are single mothers who got pregnant when they were still adolescent. They provide testimonies on various YouTube channels, openly available and watched by many of our young/adolescent girls accessing smart phones. Majority of YouTube Channel owners are concerned with attracting many subscribers to generate incomes. Unfortunately, they provide inconsistent messages and this would be wrongly interpreted as having sex at early stage or getting pregnant might lead to popularity as a star. Majority of the questions around sexuality within the social media fraternity create more confusion, and tend to set the erroneous information as a norm especially for these vulnerable teens. Questions such as Do you have a boyfriend? Your ex? Did you have sex? Are you still virgin... as a response - How can I be a virgin unless "*Iwacu se bararoga*?" (My family does not practice witchcraft; boys do not fear me, can date me...). These talks are becoming a norm in various social media platforms.

Access to technology gadgets is increasing in Rwanda and young people are most attracted by these technologies that are linked to social media. The influence of their content cannot be underestimated. For example, those social media display nude pictures for young girls by so called "*slay queens*" and seem to promote sexual intercourse among young girls. Additionally, there are various forms of parties for instance, young people attend birthday events in closed and confidential places with an aim to erroneously explore their sexual life. Currently, there is a feeling that social media seem to be followed much more than any other communication channels. These new developments seem to compromise efforts from government and stakeholders towards teen pregnancy prevention.

4.1.6. Barriers related to the implementation of recommendations

The civil society organizations have initiated different studies and formulated a set of recommendations mainly to the government institutions. However, there is no clear plan for follow-up and strategy to influence decision-making. Generally, dissemination meetings of the findings, should not be seen as the end of the exercise. Instead, a close follow-up is imperative to ensure the formulated recommendations are translated into tangible course of actions. The findings should act as an anchor around which pillars of implementation of recommendations evolve. There is need to devise strategic mechanisms to ensure the various recommendations

reach the appropriate decision makers if one is concerned with faithful implementation of the recommendations. It was noted that following dissemination meeting, the initiators of those studies/ assessments do not envision the following strategic steps to ensure the translation formulated recommendations into tangible operational plans or actions.

V. CONCLUSIONS AND RECOMMENDATIONS

Teen pregnancy is a complex issue that needs to be addressed through a multi-faceted and multi-level approach. Being a complex subject, the overall aim of this assessment was to identify barriers affecting teen pregnancy prevention.

Below are key identified barriers and corresponding recommendations:

Key Finding/ Conclusion	Recommendations	Responsible Institution
Lack of strong coordination among actors intervening in the area of teen pregnancy prevention	Establish a strong coordination mechanism for adolescent sexual and reproductive health with an aim to create synergy among stakeholders.	MoH
	Develop a national teen pregnancy prevention plan/strategy for at least five years with clear strategic objectives	MoH
	Strengthen a joint collaborative mechanism to address the issue of scattering and duplicating efforts	MoH* & CSOs
Gaps in the Human Reproductive Health and Medical Professional Liability Insurance laws that limit healthcare professionals from providing health services to under 18 years old without consent of a parent or legal guardian	Advocate for amendment of articles limiting the access of adolescents under 18 years to healthcare services without consent of a parent or legal guardian	MoH* & CSOs
Lack of implementing instruments to support the implementation of policies and laws	Develop a ministerial order to facilitate the operationalization of the Human Reproductive Health law as an integral part of both primary and secondary education curriculum	MINEDUC
	Establish a support system/mechanism for teen mothers who dropped out of school to facilitate them to resume the schooling as a strategy to prevent subsequent pregnancies	MINEDUC* & MINALOC
Roman Catholic church-based health facilities that are not supportive of the provision of modern family planning methods	Strengthen secondary health posts to fill the gap of Roman Catholic church-based health facilities in the provision of modern FP methods	MoH
Teenage pregnancy prevention interventions focusing more on girls than boys	Design inclusive SRH interventions targeting both adolescent girls and boys	CSOs* & other actors

Limited SRH knowledge of adolescents and parents, and lack of discussions on sexuality related topics between parents and children	Establish parents peer education approach to promote parent-child discussions on SRH topics; and develop age-specific SRH educational materials for both parents and teachers to facilitate transfer of knowledge	MoH*, MIGEPROF & MINEDUC
Negative influence of social media	Develop and display through social media SRH educational messages for adolescents	MoH* & MYCULTURE
Negative attitudes of some Rwandans towards modern family planning use among unmarried women and divergent views of CSOs on modern family planning methods among adolescents	Organize a yearly consultative dialogue on teen pregnancy with all actors including religious leaders, adolescents and right holders, and CSOs to have a collective consensus in addressing teen pregnancy	MIGEPROF* &MoH
	Forge a joint consensus on the use of contraceptive methods among adolescent and develop an advocacy strategy to address the teen pregnancy.	CSOs
Lack of national represented and comprehensive research to provide a thorough understanding of teen pregnancy phenomenon	-Conduct comprehensive studies on characteristics of teen mothers, prevalence of repeated pregnancies and associated factors among adolescent girls -. Conduct a specific research on Teenage pregnancy among adolescent girls living with HIV	RRP+ and other actors

** The leading institution in implementing the recommendation..*

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ANNEXES

Annex 1: Interview Guide – National Level

1. What do you think are the main causes and factors of increase of teen pregnancies in Rwanda?
   Probe:
   i. Individual?
   ii. Familial?
   iii. Socio-cultural?

2. What are the interventions being implemented under the coordination of (Name of the Organization the Key Informant works with) to address the issue of pregnancies among teenagers in Rwanda?
   Probe:
   i. What are strategies in place?
   ii. How is the coordination of implementation of those strategies?

3. What are the challenges faced in the implementation of the interventions related to teen pregnancies?
   Probe:
   i. Gaps between planned and implemented interventions
   ii. How is the funding of interventions and activities targeting prevention of pregnancies among teenagers?
4. What do you plan and recommend to overcome the stated challenges?
   Probe:
   i. Planned interventions?
   ii. Recommendations? To who?

Thank you for your time and responses to our questions.

Annex 2: Interview Guide – Civil Society Organizations

1. What do you think are the main causes and factors of increase of teen pregnancies in Rwanda?
   Probe:
   i. Individual?
   ii. Familial?
   iii. Socio-cultural?
2. What are your organization's current interventions being implemented to address the issue of pregnancies among teenagers in Rwanda?
   Probe:
   i. Which interventions?
   ii. Which one(s) is/are most effective?
   iii. Why do you think this/these is/are most effective?
   iv. What is your organization's intervention coverage?
   v. At which level?
3. What are the challenges faced in the implementation of the interventions related to teen pregnancies?
   Probe:
   i. Gaps between planned and implemented interventions
   ii. How is the funding of interventions and activities targeting prevention of pregnancies among teenagers?
5. What do you plan and recommend to overcome the stated challenges?
   Probe:
   i. Planned interventions?
   ii. Recommendations? To who?

Thank you for your time and responses to our questions.

Annex 3: Interview Guide – Teen Mothers

1. **Socio-demographics:**
    a. Current Age in years
    b. Age at first pregnancy
    c. Parity
    d. Residence
        i. District
        ii. Sector
        iii. Cell
        iv. Village
    e. Occupation at the time of pregnancy
    f. Education level at the time of pregnancy
    g. Ubudehe category at the time of pregnancy
    h. Relationship with the Perpetrator (Family member, Boss, Peer, Educator, Other _ Specify)

2. **Teen mothers-Questions**

1. Can you please share your experience of how you got pregnant?
2. After getting pregnant, have you received any support?
   Probe:
   i. From your family and community?
   ii. Health-related service or support?
   iii. Legal aid or support?

3. What are the consequences experienced after being impregnated?
   Probe:
   i. At school
   ii. At home and community where you live
   iii. With your peers and friends
   iv. Health-related

4. The current statistics show an increase of pregnancies among teenagers in Rwanda. What do you think are the main causes of that increase of teen pregnancies?
   Probe:
   i. Individual?
   ii. Familial?
   iii. Socio-cultural?

5. As one who experienced that problem, are you aware of existing interventions to address that problem?
   - If yes, what are those interventions? (Probe: legal, Health, education…)
   - If no, what do you think it should be done to prevent teen pregnancies?

- Whom do you think has to implement that intervention? (Ministry, District, School, Health Facility, ...)

6. There are policies and strategies protecting teenagers from being impregnated. At your knowledge, what do you think are the barriers to the implementation of strategies to prevent teenagers from getting pregnant?
7. Among the interventions that should be implemented, what can be done differently to prevent or reduce the pregnancies among teenagers?
   Probe: In order to prevent teen pregnancies, considering what happened to you, what can you recommend to:
   i. Other teenagers?
   ii. Parents?
   iii. Others like boys and sugar daddies?
   iv. Government?

Thank you for your time and responses to our questions.

Annex 4: List of Interviewees

Category	Institution	Planned Interviews	Interviewed
Central Government	Ministry of Health	1	1
	MYCULTURE	1	1
	MIGEPROF	1	0
	GMO	1	0
	RBC	1	0
	MINEDUC	1	1
Local Government	KICUKIRO	4	4
	RULINDO	4	4
	NYABIHU	4	4
	NYANZA	4	4
	GATSIBO	4	0
Civil Society Organizations	RRP+	2	2
	RICH	1	1
	HAGURUKA	1	1
	CLADHO	1	1
	Profemmes Twese Hamwe	1	2
	GLIHD	1	1
	HDI	1	2
	IPEACE	1	1
	RCSP	1	1
	RNGO forum	1	1
	ABASIRWA	1	1
	CHURCH LEADER	1	1
UN Agencies	UNFPA	1	1
Teen Mothers	Community	40	40
Total		**80**	**75**

Annex 5: List of Key Informants

SN	NAMES	ORGANIZATION	POSITION
1	IRYANYAWERA Marie Claire	UNFPA	FP/RHCS Programme Analyst
2	MUHIRE Gilbert	Kigali Christian school	Head Teacher
3	NKURUNZIZA Damien	STAR SCHOOL	Head Teacher
4	HABANABASHAKA J. Baptiste	HTGS KAGUGU	Dep Head Teacher
5	GASHAYIJA Modeste	Ministry of Health	Clinical services
7	MUTABAZI Phenias	MYCULTURE	SRH specialist
8	TUYISHIME Frodouard	MINEDUC	School Health and HIV Officer
9	NSABIMANA Jeanne	Kicukiro District	Gender and Family Promotion Officer
10	GATERA Emmerance	Kicukiro District	Director of Health
11	MUNYANTORE Jean Claude	Kicukiro District	Director of Education
12	MUHIRWA Aaron	Kicukiro District	Director of Good Governance
13	KAYITESI Nadine	Nyanza District	Gender and Family Promotion Officer
14	KAYIGAMBIRE Theophile	Nyanza District	Director of Good Governance
15	KABERA Clement	Nyanza District	Director of Health
16	MUSHIMIYIMANA Edouard	Nyanza District	Director of Education
17	MANAMFASHA Jean d'Amour	Rulindo District	Director of Health
18	DUSHIMIRIMANA Mary	Rulindo District	Gender Monitoring Officer
19	NUWAYO Jean de Dieu	Rulindo District	Director of Education
20	MUJIJIMA Juliette	Rulindo District	Director of Good Governance
21	NSENGIMANA Jean Claude	Nyabihu District	Director of Good Governance
22	DUSENGE Pierre	Nyabihu District	Director of Health
23	UWURUKUNDO Monique	Nyabihu District	Gender Monitoring Officer
24	HAKIZIMANA B. Valerien	Nyabihu District	Assistant to the Director of Education
25	BENIMANA S. Billy	RICH	Project Officer
26	RUSIMBI John	RNGO forum	Project Manager
27	BAHATI Innocent	ABASIRWA	Executive Secretary
28	Dr. KAGABA Aphrodis	HDI	Executive Director
29	Dr. RUKUNDO Athanase	HDI	Program Director
30	UMUBYEYI Mediatrice	PROFEMMES	Deputy Executive Director
31	NIRAGIRE Ernest	PROFEMMES	In charge of Advocacy
32	UMURERWA Ninette	HAGURUKA	Executive Secretary
33	NYEMAZE Bosco	RCSP	Executive Secretary
34	SEMAFARA Sage	RRP+	Executive Secretary
35	TUGIRIMANA J. Berchmans	RRP+	COVID-19 & HIV Advisor
36	IZERE MUGENI Vedastine	GLIHD	Program Officer
37	MUEGAYA AMON	GLIHD	Program Officer
38	BERNARD ENZAMA	IPEACE	Program Officer
39	Pr. SAFARI Emmanuel	CLADHO	Executive Secretary
40	Pr. RUTAYISIRE Antoine	ANGLICAN CHURCH	Reverend Pastor