ATTITUDES, PERCEPTIONS AND NEEDS OF TEENAGERS, TEEN MOTHERS AND COMMUNITY MEMBERS TOWARDS TEENAGE PREGNANCY IN HUYE AND KICUKIRO DISTRICTS

Participatory Action Research Report

Funded by:
USAID through WfWI

Coordinated by:
RWAMREC

ATTITUDES, PERCEPTIONS AND NEEDS OF TEENAGERS, TEEN MOTHERS AND COMMUNITY MEMBERS TOWARDS TEENAGE PREGNANCY IN HUYE AND KICUKIRO DISTRICTS

Participatory Action Research Report

Funded by:
USAID through WfWI

Coordinated by:
RWAMREC

June 2019

Acknowledgements

RWAMREC, in collaboration with FVA and KeepCare, is extremely grateful for the financial support from USAID through WfWI; with their support, this action research on attitudes, perceptions and needs towards teenage pregnancy is a great success of Twiceceka Activity.

We are grateful to the local authorities of Huye and Kicukiro districtscovered by the research; their collaboration and advice facilitated the essential data collection.

Special thanks go to Dr. AggéeShyaka Mugabe, the researcher who led this research and wrote the report.

Finally, we would like to express our immense gratitude to allparticipants, parents, teen mothers and teenagers, who shared their thoughts and experiences in order to advance this research.

Fidèle Rutayisire
Executive Director of RWAMREC

TABLE OF CONTENTS

LIST OF ACCRONYMS

CHW	Community Heath Workers
CLADHO	Collectif des Ligues et Associations de Défense des Droits de l'Homme au Rwanda
FGDs	Focus Group Discussions
GBV	Gender Based Violence
GMO	Gender Monitoring Office
GoR	Government of Rwanda
JADF	Joint Action for Development Forum
KIIs	Key Informant Interviews
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Government
MINEDUC	Ministry of Education
MINIJUST	Ministry of Justice
NISR	National Institute of Statistics of Rwanda
NWC	National Women Council
PFTH	Pro-femmes/Twese Hamwe
RBC	Rwanda Biomedical Center
RWAMREC	Rwand Men's Resource Centre
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights'
UNSCR	United Nations Security Council Resolution

EXECUTIVE SUMMARY

The overall objective is to "conduct a participatory action research on attitudes, perceptions and needs of teenagers, teen mothers and community members, including people with disability, towards teenage pregnancy for effective implementation of the National Gender Policy and other policies and strategies that address teenage pregnancies, including the Sexual and Reproductive Health Policy". From this main objective stems a series of thespecific objectives as detailed under the introductory chapter.

The study used a qualitative approach and covered two districts purposively selected, namely Huye in Southern Province and Kicukiro in the City of Kigali. In addition to an extensive desk review, KIIs and FGDs were conducted with teenagers, teen mothers and parents of teen mothers.

One overall finding is that teen mothers have huge needs, including limited access to SRH services, reintegration of schools and acceptance in the respective families and communities. Community attitudes and perceptions towards teen pregnancy are very negative. In relation to the specific objectives, the study shows that:

- *Attitudes & perceptions:* teenage pregnancy outside wedlock is a social deviance; it is perceived as a sign of parental failure. Some parents feel like the affected girl would be sent away from the family. Due to social pressure, parents would stop the pregnant girl from school. The pregnant girl would be abandoned to the man/boy responsible for the pregnancy. In sum, the pregnant girl/teen mother suffer from social stigma, shame and dishonor (therefore hard education re-entry), and in the worst scenario discrimination, which would lead to deprivation from access to legal rights and services;
- *Needs:* Access to service points, including information on sexual reproductive health and rights, family emotional support, vocational skills, school re-integration, family and community reintegration are the leading needs of teen mothers;
- *Barriers affecting access to knowledge and skills for girls:* Social cultural expectations, household labor division, family poverty, low sex negotiation skills, and lack of dialogue with parents;
- *Challenges in accessing existing legal, health and psychosocial services* are associated with low awareness about existing services, distance from home to the service point as compared to family resources, lack of family support, limited knowledge about sexual reproductive health rights; misconception about the use of contraceptive methods and myths around sex

There are socio-cultural factors that negatively affect social reintegration of teenagers in the family and community. These include the idea that teen pregnancy is associated with parents' failure to educate their children which result into family conflicts and rejection of teen mothers, the idea of "icyomanzi", family shame, social stigma and segregation, absence of community debate on teenage pregnancy, etc.;

- *Major policy gaps:* The role of the family in sexual education and the prevention of GBV is unclear; there is a discrepancy between the policy ambitions and the budget; GBV and sexual reproductive health are superficially mainstreamed in local development plans; and there is weak coordination of existing GBV prevention initiatives;
- *Long term strategies* to prevent teen pregnancy and address the needs of teen mothers would include family and peer support and adolescent sex education right from the family.

In relation to key study findings, the following recommendations are formulated.

To MIGEPROF

- Develop a program to encourage families to engage actively in the prevention of GBV as well as adolescent sexual education;
- Strengthen the family and community mechanism for effective reintegration of teen mothers and other victims of GBV.

To MINEDUC

- Establish anti-GBV clubs in all educational structures, particularly primary and secondary schools and monitor the quality of sexual reproductive health teaching;
- Initiate school-based programs aimed at promoting positive masculinity among youth through health clubs in order to empower teenagers to prevent teen pregnancy;
- Monitor the process of school re-entry for teen mothers and ensure effective reintegration within the school community
- Appoint in all schools "animatrices" who have studied health sciences to take the advantage of their knowledge in raising awareness on sexual and reproductive health among the teenagers and the youth

To MINISTRY OF HEALTH

- Empower parents to get them actively engaged in sexual reproductive health education for their children;
- Conduct media campaigns to raise awareness of communities in general, and particularly the youth about existing services for prevention of and response to teenage pregnancies.

To MINALOC

- Conduct a national campaign to address the issue of social stigma and discrimination of which teen mothers are victims at the community and service provision levels;
- Reconsider the criteria of Ubudehe categorization by including teen mothers under category one

To MINIJUST

- Develop a mechanism to ensure perpetrators of teen pregnancies are identified, and held accountable including by participating in the process to address reparation needs of victims;

To THE DISTRICTS OF HUYE AND KICUKIRO

- Partake in the national campaign to address the issue of social stigma and discrimination of which teen mothers are victims at the community and service provision levels;
- Establish a mechanism to monitor community and family practices with regard to teen pregnancies and teen mothers;
- Ensure SRHR is assigned sufficient space in the community meetings and structures such as Umugoroba y'Ababyeyi
- Engender District Development Strategies by including as many activities as possible pertaining to gender equality, the prevention of and response to GBV as well as sexual reproductive health;
- Devise strategies to identify groups at high risks of GBV and teen pregnancy in the two districts.

To FAMILIES

- Insert in family performance contracts "Imihigo" activities pertaining to the prevention of and fight against GBV as to the promotion of awareness about sexual reproductive health;

To CIVIL SOCIETY ORGANIZATIONS

- Train selected community members from the two districts on GBV law, policy, and the sexual reproductive health rights policy as well as other relevant instruments, GBV reporting mechanism and the referral process;
- Advocate for the increase of district budget allocated to anti-GBV and sexual reproductive health activities;
- Conduct advocacy activities for MINEDUC to recruit school "animatrices" who have studied health sciences in order to take the advantage of their knowledge in raising awareness on sexual and reproductive health among the teenagers and the youth.

CHAP. I. INTRODUCTION

This study aimed at documenting and analyzing the perceptions and needs of teenagers, teen mothers, mothers and fathers towards teenage pregnancies. The end goal of the research was to generate evidence-based findings in order to conduct an evidence-based advocacy for a better implementation of Rwanda's National Gender Policy and the Sexual and Reproductive Health Policy. An improved implementation of both policies will translate into reduced cases of Gender Based Violence (GBV) among the adolescent and a better enjoyment of reproductive health rights among young people.

1.1 Research problem

The Government of Rwanda (GoR) has placed the fight against GBV among its priorities. This commitment is evidenced by a policy framework that create a conducive environment for the fight against GBV as well as innovative measures, such as the establishment of community based GBV prevention structures and reporting mechanism. Similar progress has been achieved with regard to sexual and reproductive health. For instance, there are Community Health Workers in every single part of the responsibility is to raise the population's awareness about sexual and reproductive health and rights.

However, translation of these policies and laws into effects has remained less documented, leaving a knowledge gaps on the policy implementation level, challenges faced by various stakeholders, the issues affecting teenagers, teen mothers and the youth in general with regard to GBV and sexual and reproductive health as well as policy actions that are needed to be taken to address the existing gaps. This study therefore addressed the above knowledge gaps.

1.2 Study objectives

In light of the research problem described above, this study's overall objective is to "conduct a participatory action research on attitudes, perceptions and needs of teenagers, teen mothers and community members, including people with disability, towards teenage pregnancy for effective implementation of the National Gender Policy and other policies and strategies that address teenage pregnancies, including the Sexual and Reproductive Health Policy". More specifically, the study aims at achieving the following:

- Exploring knowledge, attitudes, perceptions and needs of teenagers (boys and girls), teen mothers, mothers and fathers about teenage pregnancies, including people with disability;
- Conducting gender analysis to identify barriers encountered by young girls in accessing the necessary knowledge and skills on reproductive health;
- Assessing challenges faced by teenagers with regard to accessing the existing legal, health and psychosocial services;
- Identifying socio-cultural factors that negatively affect social reintegration of teenagers in the family and community;
- Identifying policy gaps in government efforts to eradicate teenage pregnancies
- Formulating recommendations to address identified gaps for a more effective implementation of government policies and strategies to address teenage pregnancies;
- Produce a policy brief for advocacy purposes.

1.3 Scope of the work

This study was conducted in two districts of Rwanda, namely Huye in southern province and Kicukiro in the City of Kigali. The main participants were selected from:

- Selected schools (primary and secondary) from both districts;
- Selected teen mothers;
- Selected mothers and fathers;
- Resource persons from relevant government institutions and civil society organizations.

CHAP. II. METHODOLOGY

As mentioned above, this study was conducted in two different districts of Rwanda, selected purposively. Under this particular project RWAMREC works with stakeholders in Huye and Kicukiro.

2.1 The approach

The study used exclusively a qualitative approach to ensure that the study is informed by, and reflected the level of implementation of the National Gender Policy and other relevant policies and strategies realistically. The process to collect information was marked by the participation of various key stakeholders namely teenagers, teen mothers, their mothers and fathers. All these categories of key informants have been involved by means of Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) in order to address various aspects of the assessment.

2.2 Process

Regarding the process, the study went through the following steps:

- *Planning & Preparation:* In addition to the inception report that detailed the methodology to be used and defined the study plan, this phase focused on planning of the field activities and the training of research assistants to ensure understanding of the study objectives, tools and process. Under the preparation phase, consultations to identify key informants and documentation have been conducted;

- *Data Collection:* It consisted of the actual fieldwork in Huye and Kicukiro districts. During this phase, the researcher conducted the review of existing literature, KIIs and FGDs with selected teenagers from primary and secondary schools, teen mothers, mothers and fathers from community members in the selected two districts as well as selected district officials.

- *Data analysis and report drafting:*The key patterns from data have been identified and organized into coherent categories corresponding to key objectives of the study as enlisted above, particularly those pertaining to teenage pregnancies and GBV. Each theme was numbered,and the corresponding ideas grouped and closely analyzed. The emerging themes from each interview were rigorously scrutinized to understand their meaning and to know where they fit.

Where feasible and relevant, data is triangulated using different secondary sources in order to ensure quality and more precisely study findings credibility.[1] The analysis of information ultimately aimed at producing a coherent report based on the findings.

2.3 Data collection methods

A number of methods have been used to collect information; these include the desk review, KIIs, and FGDs.

2.3.1 Desk/literature review

The desk review focused on exploiting existing regulatory and policy frameworks, including the National Gender Policy and the Sexual and Reproductive Health Policy. Various reports and information materials relevant to the objectives of this study have been equally considered, particularly those from the gender and health sectors. The desk review served as an entry method, to enable the researcher to deeply understand the context and develop appropriate KII and FGD guides.

2.3.2 Key Informant Interviews

Knowledgeable persons in the areas of adolescent reproductive health and gender as well as relevant service providers from the districts and sectors where the study was conducted have been engaged by means of research individualized conversations. Information was gathered through onsite, in-person interviews using a comprehensive guide. In addition, informal conversations around sexual and reproductive health with schools managers and local authorities have been conducted. In total 5 interviews have been conducted, including with a school director for discipline, in charge of social affairs at the sector and a health facility responsible.

2.3.3 Focus Group Discussions

FGDs have been held with selected teenagers, teen mothers, mothers and fathers from schools and communities. Both girls and boys have been involved, in homogenous settings in order to encourage free expression. In total, 10 FGDs have been organized, 5 in each district with the following categories:

- 2 FGDs with teen mothers (1 in each of the two districts);
- 4 FGDs with teenagers (2 in each district: one with girls and another one with boys); and
- 4 FGDs with parents of teen mothers (2 per district: one with female parents and another one with male parents per district).

1. Patton, Michael Q., Qualitative Evaluation and Research Methods (Sage Publications: Newbury Park, Calif., 1990); Miles, Matthew B., & A. Michael Huberman, Qualitative Data Analysis: An Expanded Sourcebook (Sage Publications: Thousand Oaks, Calif., 1994)

CHAP.III. ATTIUDES, PERCEPTIONS AND NEEDS TOWARDS TEENAGE PREGNANCY IN HUYE AND KICUKIRO DISTRICTS

Study findings

As described in chapter one above, the overall objective of this study was to document and analyse attitudes, perceptions and needs of teenagers, teen mothers and community members, including people with disability, towards teenage pregnancy. This implies a look at the implementation of relevant policies and strategies, including the National Gender Policy and other policies, such as the Sexual and Reproductive Health Policy that address GBV and teenage pregnancies and GBV.

3.1 Brief overview of the policy framework and context analysis

In recognition of the prevalence of GBV and in the attempt to address GBV, the government of Rwanda multiplied initiatives aimed at preventing GBV, responding to cases of GBV and providing services to victims of GBV. These initiatives range from policies and laws to dedicated structures from the central to the lower level. The existing policies, as summarizedin table below pay a particular attention to the youth from both the anti-GBV and sexual reproductive health perspectives.

Table 1: Key GBV Prevention and response policy and legal framework

No	***Laws***	***Indicative gender equality/anti-GBV changes/ ambitions***
1.	The Constitution of 2003 revised in 2015.	It provides for equal rights between men and women and recognizes only civil monogamous marriages as a way to prevent GBV
2.	Rwanda Penal Code of 2018	According to the Penal Code, any sexual intercourse with a child under the age of 18 years old, whether or not the child consents, is being given the due special attention when it comes to deterrents or punishments. The Code reads: "If child defilement is committed on a child under fourteen (14) years, the penalty is life imprisonment that cannot be mitigated by any circumstances," is provided for.
3.	Law Nº32/2016 of 28/08/2016 governing persons and family & Law Nº27/2016 of 08/07/2016 on matrimonial regimes donations and successions	Equality in property and inheritance rights between men and women, boys and girls… …(art. 54 of succession law; see art 218 of family law). Both laws are expected to reduce economic vulnerability of women and girls while promoting their status

4.	Law N°54/2011 of 14/12/2011 relating to the rights and the protection of the Child.	Protection of girls from forced and early marriage among other noticeable changes
5.	Law N° 43/2013 of 16/06/2013 governing land in Rwanda	Equal land right between men and women; boys and girls; contributes to women economic empowerment, and therefore reduced risk of GBV
6.	Law No 59/2008 of 10th September 2008, on the Prevention and Punishment of Gender-Based Violence	Provides for the protection and relief of victims of violence; remedies for the punishment of perpetrators of domestic violence; procedures and guidelines to be followed by courts in relation to punishment, protection and compensation of victims of violence. Also provides for several women friendly measures brought up by the law, clear definition and expansion of the notion of rape…
7.	Law No 13/2009 of 27th May 2009, Regulating Labor in Rwanda	Protects workers from GBV; protection against discrimination in the workplace based on sex and marital status; outlines remuneration during maternity and woman's right to resume work after the maternity leave
7	Ministerial order n°002/08.11 of11/02/2014 on court fees in civil, commercial, social and administrative matters	Art 2 all actions relating to the protection of a child's rights and the fight against sexual violence are exempted from paying court fees.
Policy documents		***Brief description of changes introduced***
1.	National Gender Policy (2010)	Promotion of gender equality and equity through a clearly defined process for mainstreaming gender needs and concerns across all sectors of development
2.	National Policy against Gender Based violence (2011)	Elimination of GBV through the development of a preventive, protective, supportive and transformative environment.
3.	Guidelines on the anti-GBV committees at the lower level (2011)	Description of the terms of reference for the GBV/Child Protection committees for effective prevention, referral and reporting of cases of GBV
4.	National Integrated Child Rights Policy (2011)	Creation of an environment in which child's development, survival, protection and participation are ensured.
5	Adolescent Sexual and reproductive health and right policy (2011)	Sets out the basic youth-friendly sexual and reproductive health care package to be provided by health services. The package include information on SRH and rights; access to Family Planning; antenatal, delivery and postnatal care; confidential counseling and testing; prevention and treatment for HIV and

From table 1 above, it appears that the government of Rwanda has established a policy environment to address GBV and teenager pregnancies. However, the analysis of current trends, show that both GBV and teenage pregnancies are still prevalent.

For instance, the Violence against Children and the Youth Survey show that violence against children persists despite numerous measures to curb it. The findings of the same survey show that 37% and 60% of females & males experienced physical violence before the age of 18; 12% of females and 17% of males experienced emotional violence while 24% and 10% of females and males respectively experienced sexual violence before the age of 18. In 2017, a total of 17 000 cases of teenage pregnancy were reported, and orphans and vulnerable children and children with disabilities are being most exposed to sexual abuse and exploitation.[2]

With regard to sexual reproductive heath and rights, while the level of knowledge appears high among young girls, the number of teenage pregnancies is still alarmingly high as supported by the figure above. From a report, the knowledge of any contraceptive method is high among women aged between 15-49 (99.3% in 2010 and 99.5% in 2014) and about 98.3% of girls aged 15-19 know about at least one contraceptive method. Adolescent girls are more likely to give birth in a health facility than older women; 83% of girls under-20 gave birth in a health facility, compared to a rate of 69% for all women and 97% of girls under-20 receive ante-natal care from a skilled provider (in line with the rate of 98% for all women).

More education of girls is also associated with delayed sexual initiation, later marriage and childbearing and greater gender quality. 15-19- year-old girls are increasingly knowledgeable about HIV prevention methods: the share of girls knowledgeable in this area grew from 68.1% in 2005 to 73.4% in 2010.[3] It is believed that this trend has even increased given that additional facilities have been provided, including youth-friendly centers. To the contrary, boys of the same age are not doing so well, and reports show that 74.8% of boys had this knowledge in 2005 but this fell to 67.7% in 2010 .[4]

2. Ministry of health, Violence Against Children and Youth Survey in Rwanda, Kigali, 2017

3. NISR, Rwanda Demographic and Health Survey 2010. in 2005 but this fell to 67.7% in 2010 .

4. Idem.

3.2 Knowledge about teenage pregnancies in Kicukiro and Huye districts

The phenomenon of teenage pregnancies is prevalent in Rwanda, but it is only in recent years that the issue has come to the attention of the media and research institutions. Data from the 2014-15 DHS [5] show that approximately 7% of girls aged 15-19 have already begun childbearing in Rwanda. It is believed however that a big number of teenage pregnancies go unreported cases due to social stigma and limited awareness among the parents. [6]

Despite the fact that this figure (7%) is substantially lower than in other countries in the sub-Saharan region, such as Ethiopia (12%) and Zambia (28%)[7], it represents a huge societal problem if one takes into account its consequences as described in one of the sections below. The proportion of adolescent pregnancies increases sharply with age, from 1% at age 15 to 21% at age 19 and a particular rise between ages 18 and 19.

According to the National Institute of Statistics of Rwanda (NISR), adolescent girls with no education and those in the lowest wealth quintile tend to start childbearing earlier than others. A study by the United Kingdom based Overseas Development Institute cited by Walker and others indicates that adolescent girls are highly concerned about pregnancy, as 46% of respondents aged 16-19 focused on pregnancy and the vast majority were negative[8]. Interestingly, pregnancy appeared more in stories from urban girls compared to rural girls, and it was implied that urban girls were more likely to face an unwanted pregnancy than rural and in-school girls.

3.2.1 Major causes of teenage pregnancies

Early marriage is not legally accepted in Rwanda and therefore teenage pregnancy. Consequently, teenage pregnancy is most often unintentional and due to a variety of different reasons. From FGDs with both teen mothers and their parents, there is a set of factors, which contribute to teenage pregnancies in Rwanda.

5. NISR, Demographic and Health Survey, Kigali, 2016.

6. Gender monitoring Office (GMO), Annual report 2016-2017, Kigali, October 2017.

7. See among others Maria Stavropoulou M. and Gupta-Archer N., Adolescent girls' capabilities in Rwanda: The state of the evidence, December 2017; Walker D., Samuels F., Gathani S., Dimitri S. and Deprez S. 4,000 Voices - Stories of Rwandan girls' adolescence: A nationally representative survey. London: Overseas Development Institute, 2014.

8. Walker D., Samuels F., Gathani S., Dimitri S. and Deprez S., 4,000 Voices - Stories of Rwandan girls' adolescence: A nationally representative survey. London: Overseas Development Institute, 2014.

Low Socio-economic Status

In light of the findings from field consultations, teens who become pregnant often come from families of low socio-economic status. Growing up, these children often come from families who are suffering from poverty and do not have all the necessary resources to raise their child. During a research group discussion with teen mothers in Kicukiro, the relationship between of poverty and teenage pregnancy was highlighted: "…*Urebye abana baterwa inda bakiri bato kubera imibereho mibi mu miryango yabo. Akenshi abo bana ntibiga kubera kubura amikoro, bakisanga mu ngeso mbi*"[9] (In general teenage pregnancy is a result of poor living conditions in families. Very often these children drop out the school due to lack of means and find themselves into bad behaviours).

Children from such family environment grow up to have low educational goals and successes because of the lack of involvement from their own parents. These young kids then predisposed to a negative environment end up with less ambition to succeed in school and begin making friendships with other teens who are going through similar situations as them. It is these groups of teens who begin to experiment with drugs and alcohol and do not do very well in school.

In a survey conducted by the Collectif des Ligues et Associations de Défense des Droits de l'Homme au Rwanda (CLADHO) in 10 districts[10] of Rwanda in 2016, it was discovered that pregnancy among young girls is rampant.The study revealed that 49% of the girls are impregnated by colleagues while 20% others are impregnated by family friends.[11]

Poverty or low socio-economic status is further linked to low levels of family connectedness. This means that children/youth growing up in these homes do not have strong role models or individuals to look up to or learn from. Within these low socio-economic status families, abuse is often prevalent and predisposes youth to unsafe and troubling conditions. Whether the child is being abused or witnessing domestic abuse, adolescents are being separated and disconnected from their families, which might lead to poor decision-making. This lack of family connectedness pushes youth away from confiding in the adults within their homes but towards other troubled youth suffering in the same ways.

9. Kicukiro, may 10, 2019.

10. Bugesera, Gasabo, Gicumbi, Kamonyi, Karongi, Kicukiro, Huye, Nyamasheke, Nyarugenge, Rwamagana.

11. CLADHO, Report on early/unwanted pregnancy for under 18 years in 10 districts of Rwanda, Kigali, 2016.

With their lack of education and knowledge about reproduction, these teens engage in unprotected and unsafe sexual activity and do not know about the available contraceptives nor do they explore their options. Even if the adolescents have some form of contraception they are using them not properly, which makes them useless during sexual activity. Teenagers simply engage in intercourse at very young ages, and may have multiple partners, which further leads to increased chances of pregnancy.

Poverty, which means the state of being poor make teenage girls to be trap by their age mates' males or older people. In a group discussion with teen mothers in Huye, one of them said the parents could not provide all learning materials for her and she used to visit a male classmate often to study with him and also take some of his books home. They liked each other more and by the time she realized they were into a serious relationship and got pregnant. Others that the study team interviewed stated their parents'kind of "pushed them into commercial sex work", and some also said rich and perceived gentlemen lured them with money and got them pregnant.

Drugs and Alcohol

During adolescence, teenagers may drink and experiment with drugs frequently with their friends at social gatherings and parties. Teens, however, do not realize the impacts alcohol and drugs have on the functioning of their brain, especially the effects of binge drinking which is consuming large amounts of alcohol during one sitting. Drinking excessively as well as experimenting drugs may lead to unwanted and unintentional pregnancy. These substances greatly affect a teens ability to logically think and carry out general thinking processes, thus increases the chances they will engage in unprotected and unsafe sexual activity. Abuse of alcohol was mentioned in all FGDs as of the major causes of teenage pregnancies in Rwanda.

Peer pressure and sexual abuse

In light of the findings from both interviews and FGDs, pressure from peers is another major cause of sexual abuse. Often females may be pressured or forced by an older male partner to engage in sexual activity. These young females out of fear may feel forced to engage in unprotected sex without a choice, particularly those coming from poor family backgrounds.

Peer pressure may also be prevalent in a different form while in relationships adolescents may be pressured by their partner to have unsafe and unprotected sex in order to express their 'love' and 'true feelings' for their partner. According to a FGD participant "*Hari ubwo umuhungu cyangwa umugabo yigomba ko muryamana kugira ngo yemere ko umukunda koko…Iyo bigeze aho hari ubwo umukobwa yisanga yamaze kugwa mumutego*"[12] (the partner may manipulate the teenager to have sex as a sign of true love, which leads often to unintended pregnancy).

12. Kicukiro, FGD of May 11, 2019.

Sexual abuse is also another reason why teens may become pregnant. Early sexual abuse has been linked to later teen pregnancies. Some children have unfortunately been sexually abused my predators or even family even prior to entering puberty. These young kids often are unable to inform a trusted adult about the situation due to fear of being harmed by their predator. These situations, further affect the child as they enter adolescence and increases chances of teen pregnancy.

Negative media influence

The media has a large effect on teen pregnancy, especially shows and pornography. These shows often glamorize pregnancy and hide the true hardships associated with pregnancy, which encourages these teens to become pregnant. The same shows create the need for sexual intercourse pushing the youth into sexual activity. Some teenage females become pregnant just so they are able to drop out of high school or to force their partners into a deeper commitment. Rebellion is also another reason why some teens will become pregnant. In order to show their independence and deem themselves as having more control over their lives, a teen may decide to have a child. Televisions glorify the idea of having a child through the promotion of these teenagers having a more adult lifestyle, with more responsibility and decision-making power.

Lack of information fuels teen pregnancies in Rwanda. According to a participant in a FGD, neither schools nor families provide enough information about sexual reproductive health. *"Nari nzi bike kubijyanye n'inzira umwana acamo kugira ngo abeho; avuke. Ntabyo nize haba murugo iwacu haba no ku ishuri!"*[13] (I knew a little bit about how a baby is made, but not too much,' confided a teen mother. "I had no education about this from my family and at school. No lessons at all related to this topic. Nothing".

Despite the visible political will and a gender progressive policy, life for many women and girls is both disadvantaged and precarious. Raised to be obedient, subservient and have little to no voice in terms of their own future and rights, Rwandese girls are quite often subjugated by society at different levels and not least in terms of their sexual and reproductive health. The Rwandese culture is very patriarchal. As a result, so women and girls do not have power to make decisions for their own self, particularly when it comes to sexual reproductive rights. Sex is still a taboo even though sexuality education is part of the curriculum, often the teacher is not confident to deliver the information, and it is not something they feel comfortable to talk about. They feel they cannot introduce these ideas to children. Sex is reserved for those who are married, said a teacher in an interview.[14] Similarly, from field consultations, the ever-increasing number of unwanted teenage pregnancies in Rwanda is usually attributed to lack of sex education right from the family.

13. FGD with teen mothers in Kicukiro, May, 11, 2019.

14. Huye, May 10, 2019

3.2.2 Consequences of teenage pregnancies

Participants in this study are aware about the effects associated with teenage pregnancies. The following paragraphs highlight the most important consequences as described by the study participants. These consequences affect both teen mothers and their children. The study team found out that teenage pregnancy has an adverse effects and consequences on the individual or victim, family, and the society as a whole. The following are some of the effects or consequences: school dropout, fatherless children, street children, arm robbery, dependency burden, death, increase of economic hardship, spread of diseases,abortion, and family conflicts.

a) Consequences on teen mothers

Due to becoming pregnant during adolescence, teen mothers are very likely to drop out of school because of their low ambitions and dedication to getting an education in Rwanda. Worldwide figures show that about 38% of female teens who have a child before the age of 18 complete their high school education by the age of 22. This means that a very high percentage of teen mothers will not even go on to graduate from high school let alone pursue post-secondary education .[15]

In light of the above, these young girls do not have full qualifications for proper jobs in the future, which leads to having a job with very low wages or even worse, unemployment. Further, this leads to poor living conditions and the inability to maintain a safe and clean environment for their new-born child. These young women often end up living on welfare and do not have adequate resources for their child. Overall, these young girls are forced to delay and postpone any plans for their future in order to raise their child.

Another issue associated with teen pregnancy is the young mother is often forced to essentially give up her identity for a new one while switching into a maternal role. These young mothers go through many physical changes: from adolescent physical adjustment to having to adapt to the ever-changing shape of her body through the pregnancy and her postpartum figure.

15. For more details see: https://login.ezproxy.library.ubc.ca/login?qurl=http%3a%2f%2fubc.eblib.com%2fpatron%2fAuthentication.aspx%3febcid%3d110f0929e9614b8baaebc305cd841d8a%26echo%3d1%26userid%3d%255Eu, Accessed on June 11, 2019

Teens are often forced to become reliant on their family for financial resources as well as support to help get her through raising a child. In some cases, teens are shunned by their parents and do not even receive any support from their parents who are not accepting of the pregnancy. These young girls are often forced to lose contact with friends and others in their social groups in order to focus on their pregnancy. Field consultations in Huye and Kicukiro confirmed this trend. It appeared during discussions that a good number of teen mothers are chassed away from their parents home, which perpetuates the chances of falling pregnant again for survival purpose: *"Hari abana benshi birukanwa n'ababyeyi babo iyo bimaze kugaragara ko batwite. Kugira ngo babone uko babaho, aba bana bisanga bongeye gutwita kugira ngo babone ubufasha bwo kubabeshaho…Uku niko bisanga bafite abana benshi batazi ba se"* .[16]

Pregnant teens often do not have the proper healthy habits in order to go through a successful child rearing process. These mothers thus have heightened health risks, which inhibits healthy child development. Young women can suffer from things such as anaemia as well as blood pressure, which is only possible during pregnancy.

Having a child during these essential years truly clashes with the developmental tasks that should be occurring during adolescents. These young mothers are unable to fully develop a sense of self-identity because of their new role as an expecting mother. Further, peer and social relationships are strained or even terminated and teen years are essentially for developing relationships with others and discovering oneself. Due to all of these factors, teen mothers may end up developing depression after essentially being alienated from their family and friends.

Pursuing this further, teen mothers are often strained for resources and social support from the father of the child. In some cases, the teen father will remain present throughout the process and in others the father will not. If the father remains present there is often high relationships tension and dissatisfaction because of the lack of financial resources, support and child care which will be needed. There is an increase in conflict, which may lead to breakups, leaving the mother to be a single parent or even violence within the relationship. Due to the lack of financial resources, these young women often do not get prenatal check-ups or regular check-ups for their developing child and thus they are unaware of any health concerns for their child. More specifically, teen mothers face the following challenges in Rwanda.

16. Kicukiro, May 10, 2019.

Maternal death

- Adolescent pregnancy has an overall negative impact on young women's health, education and employment opportunities in Rwanda. Accdording to the Government of Rwanda, pregnant adolescents are at a high risk of health complications as they lack the biological maturity for reproduction, and they also lack experience in caring for newborn babies.[17] Adolescent girls therefore face a greater risk of dying from a pregnancy-related cause ,[18] with Rwandan women aged 15-24 accounting for 47% of maternal deaths in the country .[19]

- Nonetheless, Rwanda's overall Maternal Mortality Ratio decreased by 50% from 2000 to 2010, and these declines are associated with skilled birth attendance. Between 2000 and 2010, the presence of a skilled provider during childbirth increased from 31% to 69% .[20] Along with skilled birth attendance, the Ministry of Health's 2011 Adolescent Sexual Reproductive Health and Rights Policy focused on access to information on family planning, antenatal care, delivery and postnatal care. Indeed, in 2014-15 almost all adolescent girls with a live birth received antenatal care from a skilled provider, the vast majority from a nurse, and almost 95% also delivered in a public health facility with assistance by a skilled provider. However, only 43% had a postnatal check-up in the first two days after birth (NISR et al., 2016).[21]

Abortion

- Since a good share of sexually active adolescent girls are not using contraception, and strong sanctions exist against having a child while unmarried, adolescent girls often have no other choice but to obtain an abortion in secret.[22] It is estimated that 22% of unintended pregnancies in Rwanda end in induced abortion, and one-third of these take place in Kigali. This is probably because young women from various districts travel to the capital where it may be easier to have an abortion ;[23]

17. Government of Rwanda (GoR), Thematic Report on Fertility. Kigali, 2012 (NISR).

18. Abbott P., Homans H., Malunda D., Mutesi L., Ngoboka G., Rugira L. and Rwirahira J., UNFPA Rwanda 6th Country Programme, End of Line Evaluation. Kigali: UNFPA, Kigali, 2012.

19. Unicef, Rwanda Country Programme Document 2013-2018. New York: Unicef, 2012.

20. Idem

21. NISR, Op. Cit., 2016

22. Basinga P., Moore A., Singh S., Remez L., Birungi F. and Nyirazinyoye L. 2012a. Unintended Pregnancy and Induced Abortion in Rwanda. Causes and Consequences. New York: Guttmacher Institute.

23. Idem

- Young women did manage to successfully lobby for reform of the Rwandan abortion law in 2012.[24] Previously, abortion was only permitted when two physicians certified that it was needed to protect a woman's physical health, but the reform expanded legal grounds for abortion and now include cases of rape, incest, forced marriage and foetal impairment. Yet the law remains extremely restrictive and thus virtually no safe legal abortions take place in Rwanda .[25] It is estimated that 1 in 40 women of reproductive age has an abortion every year and 1 in 100 will experience life-threatening complications [26]

- These unsafe procedures can result in increased risk of maternal mortality and morbidity, including obstetrical fistula and secondary infertility[27] Approximately 40% of abortions lead to complications requiring treatment, but only a third of those obtain treatment.[28] The punishment for women who are convicted of having an illegal abortion is severe, including fines and lengthy prison sentences.

Vulnerability to HIV and AIDS

- Both parents of teen mothers and teen mothers themselves are highly aware of the high risks risk to be contaminated by HIV. Women and girls have a higher HIV prevalence rate than their male counterparts in every age group average HIV prevalence rate – stable over the past decade – is 4% among women of reproductive age and 2% among men. Among girls aged 15-19, it is 0.9% compared to 0.3% of their male counterparts[29] The gender differentiation is particularly pronounced among young people, where young women aged 18-19 are 10 times more likely to acquire HIV than young men of the same age.[30] Data from the last two RDHS surveys show that the percentage of HIV-positive girls increased from 0.8% to 0.9%, while the percentage of HIV positive boys remained the same.[31]

24. Umuhoza C., Oosters B., van Reeuwijk M. and Vanwesenbeeck I. 2013. 'Advocating for safe abortion in Rwanda. How young people and the personal stories of young women in prison bought about change'. Reproductive Health Matters 21(41): 49-56.

25. Basinga et al., Op. Cit.

26. Abbott P., Mutesi L., Tuyishime C. and Rwirahira J. 2014. Reproductive and Sexual Health in Rwanda: A Review of the Literature and the Policy Framework. Kigali: IPAR.

27. GoR, Op. Cit., 2012

28. Basinga, Op. Cit., 2012

29. NISR, Op. Cit., 2016

30. Bloom S.S., Cannon A. and Negroustoueva S., Know Your HIV/AIDS Epidemic from a Gender Perspective, Rwanda Report. Chapel Hill, North Carolina: Measure Evaluation and USAID, 2014.

31. NISR, Op. Cit. 2016

Family conflicts

- From field consultations in Huye and Kiculkiro, usually teenage pregnancy results in conflicts between the girl's parents and the guy or boy's parents. In the worst scenario, such pregnancy results into conflict between the pregnant teen and her parents: "*Hari ababyeyi benshi bananirwa kwihanganira abakobwa babo iyo batwite, bityo bakabangaza*" [32] (Many parents of pregnant teens fail to support their children, which results into expulsion from home);

Other consequences

- *Many teenagers who get pregnant are not able to complete their education.* Their friends may laugh at them and feel shy of going back even if their parents can take care of the newborn baby. Also the teenage mother may lack behind even if she go back to school. Due to fear of social stigma, pregnant girls find it extremely difficult to continue their schooling. This issue was reported in every single FGD;

- *Fatherless or bastard children:* many children born by teenage mothers do not know their biological fathers because the guy or man responsible often do not accept to be the impregnator;

- *Street children:* some children born by teen mothers may end up by being street children. This happens because; the teen parent(s) may not take proper care or cannot afford to provide for the children.

- *Dependency burden and increased economic hardship:* teenage mothers or parents and babies put their burden on their relatives hence adding to the relatives' problems.

b) Consequences on the child

In light of field consultations and observation, the child of a teen mother is very likely to live in poverty because of its mothers' lack of financial resources. Essentially, the birth of this child becomes the beginning of a perpetual cycle in many cases. The child is likely to endure many of the same issues its mother did in her childhood. For instance, the child is likely to grow up in poverty and in very poor conditions. They are likely to be missing a father figure, leaving them with fewer role models and increased chances of confiding in other children in the same situation. The children's academic success is also further compromised and these children do not strive to achieve much academically.

32. FGDs with female parents of teen mothers, Huye, May 11, 2019.

- Furthermore, these kids have social problems and are unable to make friends very easily which leads to poor relationship development. This is a crucial stage in adolescence. Poor relationship development can be linked to the child being deprived economically as well as educationally. The children are likely to drop out of high school just like their mothers did and also succumb to the use of drugs and alcohol due to lack of parental involvement and monitoring. Based on the study findings, the cycle is very likely to repeat itself over and over.

- Even so the issue was not reported during the study conversations, our own analysis leads us to consider that children born of teenagers in Rwanda are often also likely to suffer health risks in comparison to those born to adults. They are likely to be cognitively impaired and also susceptible to behavioural issues.

3.3 Attitudes and perceptions vis-à-vis teen pregnancies in Huye and Kicukiro

As stated above in the objectives, one of the focuses of this study is to gather information on community and parents attitudes and perceptions on teen pregnancy in the two districts covered by the study. Overall, from the interviews and group discussion insights, it appears that attitudes and perceptions are still hostile to teenagers' reintegration after delivery.

Teenage pregnancy is seen as a social menace and common public health problem. It is detrimental to both mother and child because teenage mother is not physically, psychologically and economically ready to bear a child. This phenomenon has multiple adverse consequences as described above on maternal health, child health and the wellbeing of the society as a whole.

In light of the findings, the following key elements emerge in relation to perceptions and attitudes vis-à-vis teenage pregnancy.

- For some parents, a teenage pregnancy outside wedlock is *a social deviance;*
- For others, teenage pregnancy is a sign *of parental failure;*
- Common attitudinal behaviour suggests that the affected girl would be sent away from the family, parents would stop her education and that the girl would be abandoned to the man/boy responsible for the pregnancy;
- Although the trend of the Government of Rwanda is to keep adolescent mothers in school, implementation of the laws and policies frequently falls short, and monitoring of adolescent mothers' re-entry to education remains weak overall. Family financial constraints and social stigma associated with teenage pregnancy negatively affect adolescent mothers' willingness to return to school or ability to catch up with learning;

- *Stigma, shame and dishonor:* Some participants in the study reported that whenever teenage girls get pregnant, they end up being stigmatized because it brings shame and dishonor to the family and community. Such girls are also counted as deviant persons. Teen mothers felt that teenage pregnancy was associated not only with stigma, but also with discrimination. This was also reflected in both focus group discussions with parents of teen mothers. They reported that once a girl become pregnant, she gets shame to herself, her family and to the whole community: *"You are despised in the community. When you pass in the community every one point fingers at you, some saying, look at her, she is very young and yet is pregnant"*[33], regretted a teen mother during a discussion

- *Similar statements were recorded in Huye during discussions with young girls: "...some will totally discriminate you and look at you as a meaningless person and you will never be meaningful in the community and they say what is she going to do today and tomorrow?. They forget that it is just one of the life challenges one is going through"*. Testimonies in the same line were plenty: *"...I noticed something from her close friends, all of them segregated her and they used to run away from her"*, added another teenager who knows a teen mother in her neighborhood;

- *Teenage pregnancy as a sign f being a prostitute:* Teenage pregnancies were directly associated with a bad sexual habit of a person. Anyone who has a pregnancy in teenage would be considered as a prostitute or a slut whereby pregnancy was considered as a sign (stigmata). Pregnancy was considered as an outcome of a girl's sexual behavior with many men. According to a father of a teen mother *"…the community counts a teen pregnant as a child prostitute who has ended up with a pregnancy. It takes it as a personal behavior and she is the one who wanted it"*[34];

- *Bad luck:* Getting pregnant is regarded as bad luck because not all teenagers who had sex ended up becoming pregnant: *"If that happens, I think that will be a bad luck and accident which I think I will need to talk to her parents. But this will need understanding parents because it is like an emergency. If they will not understand me and they are planning to send me to the police, I will advise the girl to abort the pregnancy"*, declared a young boy. The idea that teenagers who fall pregnant are not the only ones to have sex is common among community members.

33. Kicukiro, May 10, 2019.

34. Idem

3.4 Major needs of teen mothers

Based on the findings of this study and quick assessment conducted by Keep Care and FVA, teen mothers expressed a number of pressing needs that can be summarized as follows.

- *Limited access to Sexual and Reproductive Health and Rights (SRHR) services:* Despite the existence of good policy provisions, the majority of teen mothers have limited access to SRHR services, including information on sexual reproductive health. In the majority of rural areas, service points are situated far from homes of teen mothers, which prevent them from reporting for services. Parents themselves have limited knowledge on available minimum package meant for teen mothers. Limited awareness is coupled with the need not to reveal that one's teenager has fallen pregnant to avoid social stigma and shame.

- *Lack of family support:* Social norms are still strong in Rwanda, particularly in the rural setting. This leads to rejection of teen mothers by their own parents who find it heavy to bear the weight of social pressure. This is how teen mothers are deprived from accessing services to which they are entitled because they are still too young and need the support and guidance of parents. One common issue that was mentioned is non-registration of babies by teen mothers who don't know where to report hesitate to report to civil registry offices due to fear of social pressure.

- *Limited opportunities to integrate vocational training facilities:* In the majority of cases, once teenagers fall pregnant, they drop schools due to insufficient finances and social pressure at school. The policy provides for alternative education opportunities, including vocational training. But in practice teen mothers find it difficult to reintegrate schools due to their new responsibility of mothers who have to look after their children. In addition, vocational training facilities are still limited;

- *Weak reintegration in families and communities:* While the national anti-GBV law provides for a huge family and community role in the reintegration of victims, practically the way this should be done is not addressed. Teen mothers struggle to survive themselves and to find their own places. Their process of reintegration is affected by weak or lack of effective mechanism at the community level. In their struggle to survive and cater for their children, and in the absence of family support, some teen mothers find themselves with a second or third child.

3.5 Barriers affecting access to knowledge and skills on SRH for girls

There are numerous factors affecting access by young girls to sexual and reproductive health knowledge and skills in the context of Rwanda. These factors are interrelated and exercise a huge influence on the ability of girls to access to sexual and reproductive services, including knowledge.

Culture and cultural beliefs: In light of FGDs with both teen mothers and teenagers, culture and cultural beliefs act as an inhibiter or better still a deviant in mediating and addressing issues of sex and sexual and reproductive health. Participants in discussions explained that it is a taboo to talk openly about sexual and reproductive issues in their families. Teenagers explained that senior or elderly members of the family are the ones responsible for talking about sexual and reproductive health issues with children, but parents are reluctant to do so: *"In our culture issues of sexual and reproductive health are done through schools or other initiation spaces, not by parents"*.[35] According to parents, it is difficult for them to discuss sexuality with their children: *" For instance, we are embarrassed to talk with our daughters about menstruation"*, confessed one of the FGD participants. Similar statements were heard from parents:*"Our culture does not allow us as parents to directly talk to our children about issues of sexual and reproductive health, it is the responsibility of other senior members of the family, teachers and peers"*, reinforced another parent. *"Matters to do with sex are traditionally a taboo in our culture, such are private subjects, not befitting public discourse"*, concluded a male parent in another group discussion ;[36]

Feeling of shame: numerous statements from adolescents (both girls and boys) revealed that they do not openly communicate with their parents because their parents are strict and they fear that they will be embarrassed and misunderstood. For example, adolescents said: "*… we don't even want to imagine the shame. When we are watching TV and they broadcast scenes about sex, our fathers more so than our mothers immediately change the channel. We feel embarrassed and it is apparent that both parents are embarrassed too*".[37] In the same vein, teenagers added that they *"feel ashamed to talk to their mothers about sex and sexual health issues. Sex is something personal that shouldn't be discussed with one's parents. Once you start having this conversation with them they will assume that you have transformed from childhood to adulthood. Even to face our parents after such a discussion will be difficult.*

35. FGD with parents of teen mothers, Kicukiro, May 10, 2019

36. Huye, May 10, 2019

37. Kicukiro, FGD with teenagers, May 11, 2019

We think our mothers will always give us that eye of condemnation thinking that we have started sleeping around with boys".[38] In addition, female parents commented: *"It is very difficult as a woman to discuss anything that concerns sex with your son. We feel embarrassed..."* [39] Most parents cited that it is not appropriate to discuss issues pertaining puberty, condom use, sexual transmitted infections and contraceptives because their children are still too young. As the age of the children increases, parents stated that they feel more comfortable discussing sexual and reproductive health issues with them, but there was no evidence to corroborate such statement. Parents were found to experience a feeling of shame exactly the way children feel: *"Our daughters are too young to hear us explain how sexually transmitted infection are contracted. We feel ashamed to share ways of preventing them. We will talk to our daughters when they are old enough*.[40]

- *Sexual experimentation ideology:* In addition to the feeling of shame and cultural beliefs, parents raised the concern that engaging in discussions on sex and sexual and reproductive health issues is likely to encourage their children to indulge in sex. A good example of this perception is illustrated by the following extract: *"…Children are curious, introducing these ideas in their heads will just lead them to try it out and engage in sex. We can't talk with our children about sex because this will be like we are directing them to engage in sexual activities"*.[41] It was said that one should feel ashamed to talk with their children about condom use, and pregnancy prevention methods because these children are still too young to know all of these sensitive issues.

- *Limited access to services:* A series of multifaceted barriers currently prohibits good sexual and reproductive health for adolescents in Rwanda despite the fact that adolescent sexual and reproductive health is a high priority of the government. Judgmental attitudes about sexual activity abound, especially for those out of marriage and sexually active girls and women.With regard to service-related barriers, poor health systems for sexual health, and family planning are common, with unmarried adolescents hesitating or failing to report to health facilities due to long distance and/or lack of information. From discussions with teen mother, there is an overall deficiency of youth-friendly services. Lack of integration is seen where services that might address counseling and family planning fail to include HIV/Sexually Transmissible Infections care, etc. Services are also hampered by insufficient availability of supplies and equipment. Financial and physical accessibility restrict adolescents' access to services where they do exist.

38. Huye, May 11, 2019
39. Huye and Kicukiro, May 10, 2018
40. Idem.
41. Kicukiro, May 10, 2019

On a personal level, young people's care-seeking behavior may be restricted because of fear (of people finding out and other confidentiality issues that may result in violence), embarrassment, lack of knowledge, misinformation and myths, stigma, and shame. A range of people have an influence on adolescents' access to information and services, including peers, parents, family members, teachers, and healthcare workers. During discussions with teen mothers, some argued that the single most important barrier to care is *provider attitude*. Many healthcare workers deter adolescents from using services because of their lack of confidentiality, judgmental attitudes, disrespect, or not taking their patients' needs seriously.

3.6 Challenges in accessing existing legal, health and psychosocial services for victims of GBV

There are numerous challenges that affect access to existing legal, health and psychosocial services by adolescent. Recent studies identified several challenges,

- Low awareness among adolescent and parents about existing services. for victims of GBV and teen pregnancies.
- Lack of family support and taboo character around sex .
- Distance from home to the service point as compared to family resources.
- Limited knowledge about sexual reproductive health rights.
- Misconception that condoms will get stuck inside their bodies and will have to be removed by clinicians who will then become aware that they have had sex.
- Common myths in Rwanda including the idea that having sex will prevent pain during menstruation or will improve a skin condition.

Other challenges are associated with : [42]

- Low awareness among community members and some local leaders about the GBV referral pathway from Umudugudu (village) to the Isange One stop Center or other service points depending on each type of GBV;
- Lack of harmonized format for reporting of GBV cases;
- Collection and preservation of GBV evidences throughout the whole process from referral, reception to filing to court;
- Taboo character around sex that leads to silence about cases of GBV and protection of perpetrators;

42. Women for women international, United towards a Rwanda free from gender based violence: Analysis of GBV policy implementation gaps, Kigali, November 2018.

- Not all Isange One Stop Centres Offer full package of GBV services;
- In some instances GBV victims report receiving bad treatment (reception) and poor care as some are told to buy some medicines outside the centre on their own while by standards the centre is supposed to provide them.
- Unprofessional attitudes of some GBV services providers, leading to re-victimization GBV victims;
- Little support to teenage mothers: rejection of teenage mothers by both the family and society at large making them more vulnerable and exposed to further risks of sexual exploitation;
- Absence of reintegration mechanism for teen mothers and other victims of GBV;
- Insufficient legal support to GBV victimsowing to a lack of forensic evidence to support cases in courts and limited or delayed reporting of GBV cases;
- Lack of specialized prosecutors trained specifically for handling GBV at all levels making it a long process for GBV victims to get justice;
- Lack of safe rooms at the community level.

3.7 Socio-cultural factors that negatively affect social reintegration of teen mothers in the family and community

Teen mothers face a serious reintegration challenge due to attitudes and perceptions on teen pregnancy. In light of discussions held with both teen mothers and their parents, teen pregnancy associated with "parents' failure to educate their children" the idea of "icyomanzi", family shame, social stigma and segregation, etc.

Overwhelmingly, study participants discussed community attitudes that were negative, unsupportive, and socially and culturally unaccepting of adolescent SRH. Sexual activity, and its consequences, including pregnancy, childbearing, abortion, STIs, and contraception and family planning service use, were described as "acts of disobedience," "disrespect," and were in direct conflict with established norms for acceptable, appropriate behavior for adolescents or young women. A major premise of community norms was the belief that premarital sex is immoral, and disobedience was described as a failure to follow religious teachings. According to a female adolescent, premarital sex is simply deviance: *"From the bible, when you are not married, it is not advisable to have sex and the doctrines we are given state that having sex is not good but really bad at this stage. You will begin to spoil yourself if you have sex, and you can easily get pregnant, sexually transmitted diseases, and a lot of illnesses."*[43]

43. Kicukiro, May 11, 2019.

The belief that adolescents are not developmentally "ready" or "responsible" for sex was repeatedly raised and its consequences was another underpinning of negative attitudes. Maturity and preparedness (financial independence) were considered prerequisites to sex and childbearing. Therefore, adolescents are not able to manage the emotional, financial, and social responsibilities required. Readiness was also described as educational attainment, and sex was a competing activity. Sex and pregnancy resulted in forfeiture of students' life goals, as many teenagers mentioned.

The most consistent, vivid description of community norms was through stories of "bad girl." This language, used by many participants, referred to labeling of adolescents who engage in sexual activity, become pregnant, have abortions, or use contraception or family planning services as "bad," and "spoiled". "Bad girl"could also extend to an adolescent's family or community, leading to a "tarnished" image of her home or school. "Bad girls" are believed to result from failed parents and community leaders, as one teen mother observed: *"They always say her parents are bad because they don't teach her the right thing. Teachers are also not doing their duty and also religious leaders are not doing their part. That's why she is giving birth at the wrong age. And she's also a bad girl."*

Gossip, marginalization, isolation, discrimination, and mistreatment are forms of stigma experienced by adolescents who are sexually active, pregnant, parenting, or had used contraception or had an abortion. Gossip, the mildest form, led to further stigma as adolescent sex and pregnancy "news" traveled quickly in communities and schools. While church members were a common source, peer gossip was often the most troubling. From focus group discussions with teen mothers, reintegration is very complicated due to social stigma: *"She is mocked at if she is not married and especially if she is a teenager. She is even shy to come out, so she stays indoors because they will gossip about her and look at her. In her presence, some of her peers are friendly but when she leaves they start to insult or laugh at her. Things will change because no one wants to walk with a bad girl"* declared a female teenager .[44]

Sexually active and pregnant adolescents are routinely abandoned and rejected by partners and parents, expelled from schools or mistreated, homes, and churches, and suffer mental health symptoms such as loneliness, unhappiness, sadness, and depression. Verbal, and psychological mistreatment, being shouted and screamed at are not uncommon.

44. Idem.

Judgment and discrimination from healthcare workers was among the most commonly described sources of enacted stigma and precluded adolescents'access to quality care and utilization of SRH and antenatal/postpartum services. Nurses reportedly called sexually active adolescents "prostitutes," "too flirty," "animal-like" "low class," and "below the standard of normal people." Poor treatment was not universally described, though, and adolescents could sometimes find a trustworthy, compassionate nurse or facility that would "take them in", said a teen mother in Huye.

Negative community norms around teen pregnancy and enacted stigma contributed to individual women's experiences with internalized stigma. Self-loathing and beliefs of being "bad" and "spoiled" were consequences of sex, pregnancy, abortion, and childbearing. This collection of negative feelings - "disgrace," "shame," embarrassment, and worry about a tarnished reputation - was consistently referred to as "shy" or "kwitinya". Shyness, as described through women's stories, had a loaded connotation extending beyond its western interpretation of bashful or timid.

3.8 Mechanisms to prevent and respond to teenage pregnancies in Rwanda

Although Rwanda has high coverage of health services, it is evident from analysis that programs are not adequately reaching adolescents aged 10-19 years. Rwanda's government and partners conducted an assessment of HIV and sexual and SRH trends and information gaps related to adolescents. The results are alarming–they indicated three things:(1) new adolescent HIV infections were increasing , (2) a substantial portion of adolescents are married before age 18 and (3) adolescent pregnancy rates are rising as indicated far above. A clear reason stood out to explain these findings: little knowledge and use of Sexual Reproductive Health services by adolescents. The assessment showed gaps in some key interventions: condoms to prevent pregnancy and HIV infection, general family planning, voluntary male circumcision, HIV testing, and treatment. The next step was the development of the National Operational Plan for HIV and Sexual and Reproductive Health among Adolescents and Young Adults 2017–2020, which creates clear targets and signs to scale up HIV response for adolescents across Rwanda. The resulting Operational Plan accounts for bottlenecks that prevent optimal service coverage. This includes issues such as drug supplies and mapping the number of trained healthcare workers across districts.

Efforts had already been deployed to ensure increased access to services among the adolescents with the aim to avoid GBV, teen pregnancy and HIV. The analysis of the Fourth health sector strategic plan (2018-2024) shows that Rwanda is committed to:

- Increasing the demand for ASRH services by increasing the access to services for Adolescent and youth;
- Expanding the coverage of ASRH services (e.g increasing youth-friendly centers and corners in appropriate settings);
- Promoting the use of technology messaging to youth and adolescents; and
- Strengthening partnership with other public and private sector in the delivery of ASRH services.

The country has been implementing a number of strategies to address teen pregnancy and GBV. Part of the efforts have been deployed for:

- Family-planning counseling, information, education, communication and services, including access to safe and effective contraceptive methods;
- Education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care;
- Prevention of unsafe abortion and management of the consequences of abortion;
- Prevention and treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions;
- Information, education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood.

The findings of this study however suggest that a lot is yet to be done to ensure effective prevention of teen pregnancy and GBV. Knowledge about existing services to prevent teen pregnancy, such as the use of condom is still low. This trend confirms existing findings. According to UNICEF Rwanda and Rwanda Biomedical Center (RBC), although in general new HIV infections have been in decline, the rate of decline is slower among adolescents (0.33 per cent) than in the general population (0.27 per cent). Access to ART services is very low among adolescents and young adults living with HIV (34 per cent) and this is attributed to low uptake of HIV testing. In addition, HIV prevalence among adolescents and youth aged 15-19 years is 0.6 per cent, while among those aged 20-24 it is 1.5 per cent. There is also a clear gender imbalance in prevalence rates: young girls are five times as likely to be infected compared to boys of the same age, with a prevalence rate of 2.5 per cent among girls compared to 0.5 per cent among boys .[45]

45. Unicef Rwanda and RBC, Adolescent HVI programme context analysis, Kigali, 2015.

3.9 Analysis of challenges impeding the implementation of the anti-GBV and sexual reproductive heath policies

Despite significant progress in the fight against GBV and the promotion of sexual reproductive heath rights in Rwanda, translation of the policy into effect has been faced by a number of serious challenges. This study and some others point to a number of issues that affect effective implementation of the above-mentioned policies.

3.9.1 Weak coordination of and scattered interventions on GBV

Although noticeable progress has been made with regard to coordination and monitoring of GBV activities, in practice, gaps related to joint planning, GBV data collection and reporting skills are still undermining the quality of prevention of and response to GBV.[46] Lack of actors joint action plans that define priorities, harmonize roles and responsibilities and provide clear guidance to responsible parties. Consequently, there is duplication of activities and imbalanced geographical distribution of GBV interventions. The coordination role of the NGC has remained weak mainly due to limited resources. Consequently, various anti-GBV commitments, including the policy against GBV itself, the UNSCR 1325 and the Kampala Declaration on Sexual and Gender Based Violence are less known of potential partners, and therefore not included in their individual plans. The introduction of Joint Action for Development Forum (JADF) at the district level with the very aim to improve joint planning and coordination does not seem to have addressed the problem. The National Women Council (NWC) is represented up to the lowest level, but is weak if not dormant due mainly to lack of financial means. A recent study shows that this decentralized structure is mainly active during electoral campaigns, which lead some observers to consider it in substance as a " tool for political mobilization by people who wish to address their own interests" .[47]

46. PFTH, OP. Cit., 2017

47. Never Again Rwanda, A survey on citizen participation in Imihigo (darft report yet to be validated), 2018.

3.9.2 Limited capacity among service providers

Limited capacity among service providers has been repeatedly mentioned among the factors of ineffective implementation of the national anti-GBV policy. For instance, though capacity building sessions are sometimes organized,[48] studies have pointed to significant knowledge gaps among the judicial personnel, particularly regarding the understanding of GBV[49] and the issue of evidence in cases involving rape and other forms of sexual abuse.[50]

At the lowest levels, lack of accountability and capacity are even more important. Trocaire study further pointed to lack of skills among key duty bearers, namely local anti-GBV committees. According to this study, 37.5% and 34.5% of men and women respectively are not skilled to collect and report quality GBV data. More importantly, respectively 75.3% and 86.2% of men and women among the GBV committees declared being not skilled to contribute to mainstreaming gender into the district planning and budget documents. The guidelines governing local anti-GBV committees were issued in 2011, but are not known of the very people who are expected to implement them. Sectors, Cells and Villages face the same challenges.[51] The introduction of Inshuti z'Umuryango (friends of family)and Community Heath Workers (CHW)is a very good initiative. Their mandate is clear, but heavy given their other family responsibilities.

48. See for instance Gender Monitoring Office, Beijing +20 Rwanda country report,Kigali, June 2014.

49. Legal Aid Forum Rwanda, Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda, Kigali, 2013.

50. Pro-Femmes Twese Hamwe, Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda, Kigali, 2014.

51. Trocaire Rwanda, Holding duty bearers accountable for the implementation of the GBV policy. Final baseline report, Kigali, January 2018.

3.9.3 Superficial mainstreaming of anti-GBV and sexual reproductive health activities in the district planning documents

The concept of gender has become very popular in Rwanda without necessarily being owned by various potential stakeholders. From the experience of the author of this paper, there are two major reasons why gender is not appropriately mainstreamed in the development plans of the local governments: limited technical capacity of staff in charge and relative little importance accorded to this area. Consequently, gender and related concepts such as GBV and sexual reproductive health are superficially or vaguely included in the district development Strategies, which affect the implementation of the anti-GBV and other relevant policies. Potential policy partners, including educational structures, churches, and families do little to prevent and respond to cases of GBV. Recent evaluations of the implementation of the national anti-GBV policy pointed to inefficient documentation and low reporting of cases of GBV.[52] In spite of GMO efforts to establish GBV reporting standards, the two evaluation researches were not able to confirm whether there is a standardized tool and mechanism for reporting GBV.

For instance, the analysis of Nyamagabe District Development Plan (2013-2018) and the budget (2016-2017) shows that no single specific activity is related to GBV.[53] Gender activities are general in Gakenke, Rulindo and Nyaruguru. Only the district of Nyanza has included activities related to anti-GBV clubs in its District development Plan in a specific way. Out of the five selected districts, only three have allocated a symbolic budget to either gender equality or anti-GBV activities, namely Gakenke, Nyanza and Rulindo. On average, the gender and GBV related budget represent 0, 098% [54] of the three districts' annual budget (2016-2017).

52. See by Pro-femmes/Twese Hamwe (PFTH), Implementation of national GBV policy in Karongi, Nyamasheke, Rusizi and Rutsiro districts, Kigali, 2017Trocaire Rwanda, Trocaire, Holding duty bearers accountable for the implementation of the GBV policy. Final baseline report, Kigali, January 2018.

53 Idem

54. Gender and GBV represented 0,080 % of the total 2016-2017 annual budget in Gakenke while it stood at 0,032 and 0,183 in Nyanza and Rulindo respectively.

Despite the existence of the Gender Budget Statement, this situation suggests a critical need for inclusion of gender and GBV activities in the districts development plans and annual budgets.[55] Low prioritization of GBV and gender priorities against other competing issues affect results in a reliance on volunteers to respond to GBV issues (i.e. Friends of Families), and a lack of a true central champion at the district level to advocate and hold local stakeholders accountable. Collaboration from the line Ministry where the gender officer at the district and the gender cluster 's role could be is probably in need of support to priorities through an action plan

3.9.4 Lack of ownership and accountability of the fight against GBV among existing and potential stakeholders

The national anti-GBV policy identifies a number of potential stakeholders expected to play a leading role for effective prevention of GBV. These stakeholders include families, educational structures and churches among others. However, existing studies show that ownership of the fight against GBV is still low due to the absence of a comprehensive communication strategy and monitoring structure that provide a shared framework for accountability. It came to the attention of the author of this paper that some potential stakeholders are not even aware about the existence of the policy itself. A number of factors, including low membership in community structures working on GBV clearly show that the policy is not known. From the PFTH study, less than 30% of community members are members of such structures. The same study findings indicate that families play a little role in the fight against GBV, and yet studies have already established that most cases of GBV are committed within the family settings.[56] The situation above suggests a need for a policy wider dissemination plan to ensure all stakeholders are aware about their respective roles and responsibilities and set a basis for future accountability.

3.9.5 Persistent stereotypes and cultural traditions

Though community mechanisms such as Umugoroba w'ababyeyi (parents' evening) are becoming increasingly popular in educating communities against GBV, men's participation is still very low in many areas of the country. In addition, these structures dedicate little time to sexual reproductive health. In some district covered by the PFTH 2017 study, men have simply renamed this mechanism Umugoroba w'abagore (women's evening). The active role expected from men as provided for in the national anti-GBV policy is therefore yet to materialize.

55. Trocaire, Op. Cit. 2018.

56. PFTH, Implementation of national GBV policy in Karongi, Nyamasheke, Rusizi and Rutsiro districts, Kigali, 2017

Since men represent the majority of GBV perpetrators,[57] it is hypothetical to achieve a GBV hostile social environment without their active involvement. Stereotypes about the role and place of women persist and still affect the rights of some women particularly in the private spheres.

Negative masculinities are still common particularly in the rural areas and prevent men from supporting efforts to promote gender equality, and very often translate into power imbalance between men and women, which perpetuates GBV. In the same way, cultural traditions still prevent people from reporting cases of GBV to avoid social stigma, which affects the implementation of the anti-GBV policy.

3.10. Core strategies for long term prevention of GBV and teen pregnancies

There are many negative factors associated with teens who become pregnant, however there are some factors that increase the likelihood of making these teens more suitable for parenthood.

- *Family and peer support:*Teen mothers can prevent sexual abuse and increase their resilience through having the support of their parents as well as maintaining social relations with their peers. Having those connections throughout the pregnancy and after as well as having all of that support greatly influences the mothers' attitude and adaptation to her new role in life. Furthermore, another protective factor, which increases teen mother's resilience is if the mother goes on to graduate from high school rather than dropping out and beyond. The overall most important factor is the teen mother having the support of her own mother. The mother of the teen can be extremely helpful in terms of emotional support for her daughter as well as financial aid and helping her daughter with child rearing responsibilities of the newborn

- *Education/Knowledge*:From a young age, it is important that young children and adolescents have a reliable and trustworthy adult to confide in. Having an approachable and knowledgeable role model or adult in your life will greatly decrease the chances of teen pregnancy. Parents often neglect explaining the anatomy of the body to their children, however providing this information and educating children during their youth is an extremely important protective factor against teen pregnancy.

57. The police records and existing studies show that males represent a huge majority of perpetrators of GBV while female represent the majority of victims (more than 93%).

Children need to grow up having a positive self-image as well as a healthy environment to grow up in. Children need unconditional love and support from their parents as it is critical in ensuring the child makes better choices about their future sexual activity. Having love from one's parents ensures that these adolescents are not left feeling unwanted from parents who are very passive and uninvolved. Open communication and time spent with children is a protective factor against teen pregnancy also. Children and teens should be able to approach their parents and ask for their time whenever in need. Developing a strong relationship between child and parent is critical. These children are more likely to use birth control or other contraceptives and make better decisions in regards to sexual behaviors;

- *Adolescent sex education:* Knowledge about sexual and reproductive health is vital for adolescent girls. Yet their need for such information remains unmet and they have partial and often inaccurate knowledge based on information they get from their peers and the radio. Misinformation is particularly common in rural settings where girls are less likely to be in school. For instance, one common misconception is girls fearing that condoms will get stuck inside their bodies and will have to be removed by clinicians who will then become aware that they have had sex. Other common myths in Rwanda include the idea that having sex will prevent pain during menstruation or improve a skin condition. Reports that this type of misinformation comes from various sources, including friends and boyfriends. Girls stated that they are frequently forced to sift through scanty information and decide themselves about what is accurate.[58] Parents are also unable to provide sexual health information, while social norms instructing abstinence before marriage mean that parents often avoid discussing the sexual behavior of their daughters. For instance, in one study, 81% of parents reported that they did not discuss sexual matters with adolescents due to socio-cultural, individual and socio-environmental barriers among others.[59] The proportion of adolescent girls and boys with comprehensive knowledge of sexual and reproductive health issues generally increases with age, educational attainment and wealth.[60]

58. Girl Hub, State of Girls in Rwanda. Kigali: Girl Hub Rwanda, Kigali, 2011.

59. Bushaija E., Sunday F.X., Asingizwe D., Olayo R. and Abong'o B. 2013. 'Factors that hinder parents from the communicating of sexual matters with adolescents in Rwanda', Rwanda Journal of Health Science 2: 13-19.

60. Walker et al, Op. Cit., 2014

CHAP.IV. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The main objective of this study was to document attitudes and perceptions of community members on teenage pregnancy through the status of implementation of the national gender policy, the sexual reproductive health rights and other relevant policies.In relation to the objective above, the study findings point to the following key trends:

- A lot of efforts have been invested to raise awareness of the populations on GBV and sexual reproductive health. Community meetings and media happen to play a pivotal role in this process while families, faith based organizations and schools play a relatively minor role to raise awareness of populations and fight against GBV. The level of awareness about GBV is high, but this does not prevent GBV from being perpetrated against adolescent. GBV is still prevalent among this category and girls are several times at risk of being victims of sexual abuse as compared to boys;

- The study has noticed remarkable progress in relation to protection of victims of GBV, medical services and justice. Illustratively, there is a GBV desk in each police station, a comprehensive service package is provided to victims of GBV by the Isange One Stop Centers free of charge and under the same roof and the judicial system has introduced significant reforms, including a special GBV unit within the NPPA and measures to consider GBV part of the priority cases. The MAJ significantly contributes to access to justice among the victims of GBV through orientation and legal conclusions;

- Teenage pregnancy outside wedlock is a social deviance. Victims of teenage pregnancy suffer from social stigma and discrimination;

- Common attitudinal behavior suggests that the affected girl would be sent away from the family, parents would stop her education and that the girl would be abandoned to the man/boy responsible for the pregnancy;

- Though the Government strong political will to keep adolescent mothers in school, implementation of laws and policies frequently falls short, and monitoring of adolescent mothers' re-entry to education remains weak overall. Family financial constraints and social stigma associated with teenage pregnancy negatively affect adolescent mothers' willingness to return to school or ability to catch up with learning;

- Teenage pregnancy as assimilated to a sign f being a prostitute.Teenage pregnancies were directly associated with a bad sexual habit of a person;

- Access to services pertaining to adolescent sexual reproductive health rights is still problematic to low knowledge among the youth and limited service points. Efforts of the government to address teenage pregnancy are still nascent

Despite this progress, there are still serious gaps and challenges that affect effective implementation of the national Gender and anti-GBV Policies. For instance, only few health facilities have a staff in charge of GBV contrarily to the provisions of the national GBV Policy; health centers are not well equipped and there is few staff with appropriate skills to respond effectively to cases of GBV. There are no comprehensive permanent plans for capacity building of the personnel within the judicial system and evidence to support access to justice for victims of GBV is still a serious hindrance.

4.2 Recommendations

In relation to key study findings, the following recommendations are formulated.

To MIGEPROF

- Develop a program to encourage families to engage actively in the prevention of GBV as well as adolescent sexual education;
- Strengthen the family and community mechanism for effective reintegration of teen mothers and other victims of GBV;

To MINEDUC

- Establish anti-GBV clubs in all educational structures, particularly primary and secondary schools and monitor the quality of sexual reproductive health teaching;
- Initiate school-based programs aimed at promoting positive masculinity among youth through health clubs in order to empower teenagers to prevent teen pregnancy;
- Monitor the process of school re-entry for teen mothers and ensure effective reintegration within the school community;
- Appoint in all schools "animatrices" who have studied health sciences to take the advantage of their knowledge in raising awareness on sexual and reproductive health among the teenagers and the youth

To MINISTRY OF HEALTH

- Empower parents to get them actively engaged in sexual and reproductive health education for their children;
- Conduct media campaigns to raise awareness of communities in general, and particularly the youth about existing services for prevention of and response to teenage pregnancies.

To MINALOC

- Conduct a national campaign to address the issue of social stigma and discrimination of which teen mothers are victims at the community and service provision levels;
- Reconsider the criteria of Ubudehe categorization by including teen mothers under category one

To MINIJUST

- Develop a mechanism to ensure perpetrators of teen pregnancies are identified, and held accountable including by participating in the process to address reparation needs of victims;

To THE DISTRICTS OF HUYE AND KICUKIRO

- Partake in the national campaign to address the issue of social stigma and discrimination of which teen mothers are victims at the community and service provision levels;
- Establish a mechanism to monitor community and family practices with regard to teen pregnancies and teen mothers;
- Ensure SRHR is assigned sufficient space in the community meetings and structures such as Umugoroba y'Ababyeyi,
- Engender District Development Strategies by including as many activities as possible pertaining to gender equality, the prevention of and response to GBV as well as sexual reproductive health;
- Devise strategies to identify groups at high risks of GBV and teen pregnancy in the two districts.

To FAMILIES

- Insert in family performance contracts "Imihigo" activities pertaining to the prevention of and fight against GBV as to the promotion of awareness about sexual reproductive health;

To CIVIL SOCIETY ORGANIZATIONS

- Train selected community members from the two districts on GBV law, policy, and the sexual reproductive health rights policy as well as other relevant instruments, GBV reporting mechanism and the referral process;
- Advocate for the increase of district budget allocated to anti-GBV and sexual reproductive health activities.

4.3 Areas For Further Research

This study suggests a number of relevant topics that deserve further investigation for a deeper understanding of GBV, a more inclusive prevention environment and an effective response to cases of GBV in general and teen pregnancies in particular. Topics for further research include:

- Documenting the magnitude of GBV and teen pregnancy phenomena among People With Disabilities and other marginalized groups;
- Understanding the factors that prevent victims of teen pregnancies from denouncing perpetrators;
- Understanding the magnitude and factors of family and community mediation of cases involving teen pregnancy.

KEY REFERENCES

Abbott P., Mutesi L., Tuyishime C. and Rwirahira J., *Reproductive and Sexual Health in Rwanda: A Review of the Literature and the Policy Framework.* Kigali: IPAR, 2014

Abbott P., Homans H., Malunda D., Mutesi L., Ngoboka G., Rugira L. and Rwirahira J., *UNFPA Rwanda 6th Country Programme, End of Line Evaluation.* Kigali: UNFPA, 2012.

Bloom S.S., Cannon A. and Negroustoueva S., Know Your HIV/AIDS Epidemic from a Gender Perspective, Rwanda Report. Chapel Hill, North Carolina: *Measure Evaluation and USAID, 2014*.

Bushaija E., Sunday F.X., Asingizwe D., Olayo R. and Abong'o B. 2013. *'Factors that hinder parents from the communicating of sexual matters with adolescents in Rwanda', Rwanda Journal of Health Science 2: 13-19.*

Care International Rwanda, *Sexual and gender based violence baseline study in Gakenke and Gatsibo districts,* Kigali, February 2014.

CLADHO, *Report on early/unwanted pregnancy for under 18 years in 10 districts of Rwanda,* Kigali, 2016.

Girl Hub, *State of Girls in Rwanda.* Kigali: Girl Hub Rwanda, Kigali, 2011.

GMO,*Annual report 2016-2017*, Kigali, 2017

GMO, *Evaluation of the implementation of the 2009-2012 National Action Plan for the United Nations Security Council Resolution 1325 in Rwanda, Kigali, May 2015.*

GMO, *Beijing +20 Rwanda country report*, Kigali, June 2014.

Legal Aid Forum Rwanda, *Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda, Kigali, 2013.*

Lincoln, Y. S., & Guba, E. G., Naturalistic inquiry, Beverly Hills, CA, Sage, 1985.

MIGEPROF, *Guidelines on the setting up of committees to fight against gender-based violence and for the protection of child's rights, from Umudugudu to district levels* (no date).

MIGEPROF, *National Anti-GBV Policy and Strategic Plan*, Kigali, 2011.

MIGEPROF, *National Policy against Gender-Based Violence*, Kigali, July 2011, pp.14-15.

Ministry of Finance and Economic Planning (MINECOFIN), *Gender budgeting guidelines,* Kigali, May 2008.

Pro-Femmes Twese Hamwe, *Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda,* Kigali, 2014.

Rwanda Integrated Household Living Conditions Survey (EICV) 2013/2014, *Thematic report-economic activity,* Kigali, March 2016.

Trocaire, *Holding duty bearers accountable for the implementation of the GBV policy.* Final baseline report, Kigali, January 2018.

Umuhoza C., Oosters B., van Reeuwijk M. and Vanwesenbeeck I. 2013. 'Advocating for safe abortion in Rwanda. How young people and the personal stories of young women in prison bought about change'. *Reproductive Health Matters 21(41):* 49-56.

UN Women Rwanda, UNFPA Rwanda and UNICEF Rwanda, *Evaluation of the Gihundwe One Stop Centre for survivors of GBV and child abuse,* Kigali, March 2015.

UNIFEM, *Case study. Establishment of Rwanda National Police Gender Desk,* Kigali, 2009.

United Nations Department of Economic and Social Affairs, *The World's Women 2015, Trends and Statistics* (Chapter 6, Violence against Women), 2015;

University of Rwanda, Centre for Gender, Culture and Development, *Africa region security organs capacity building workshop on violence against women and girls: prevention, response and peacekeeping, Report of a workshop,* Kigali, 21-24 July, 2011.

Walker D., Samuels F., Gathani S., Dimitri S. and Deprez S., 4,000 Voices - *Stories of Rwandan girls' adolescence: A nationally representative survey. London:* Overseas Development Institute, 2014

Women for women international, *United towards a Rwanda free from gender based violence: Analysis of GBV policy implementation gaps,* Kigali, November 2018.

World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, 2013.