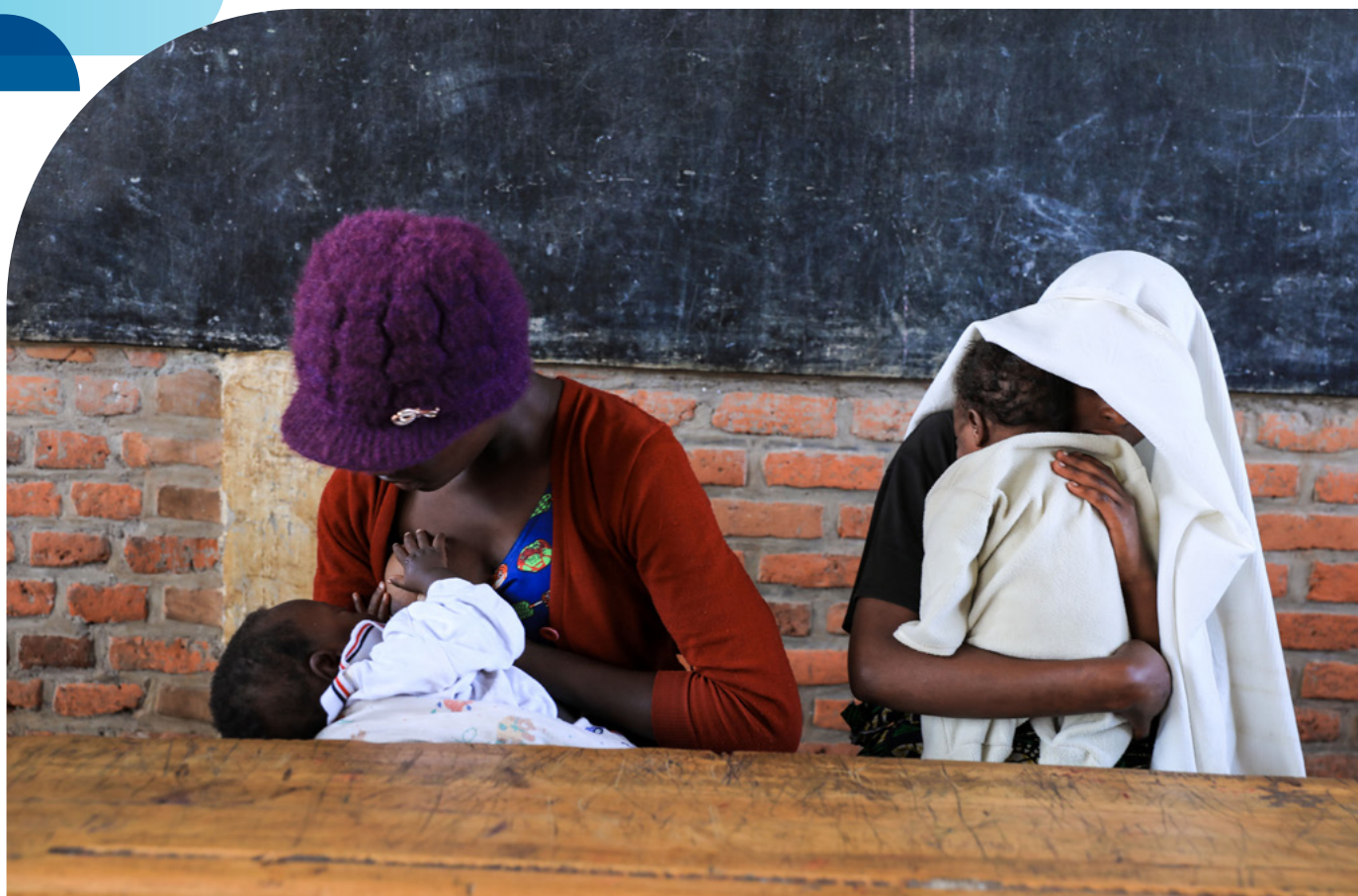
Interpeace
INTERNATIONAL ORGANIZATION FOR PEACEBUILDING

AMBASSADE DE FRANCE AU RWANDA
Liberté Égalité Fraternité

Exploring Psychosocial Factors and Effects of Adolescent Pregnancies in Rwanda:
Towards a More Effective Psychosocial Support for Adolescent Mothers

Final Report



Interpeace
INTERNATIONAL ORGANIZATION FOR PEACEBUILDING

AMBASSADE DE FRANCE AU RWANDA
Liberté Égalité Fraternité

Exploring Psychosocial Factors and Effects of Adolescent Pregnancies in Rwanda:
Towards a More Effective Psychosocial Support for Adolescent Mothers

Final Report

Researchers: Révérien Interayamahanga
Belle Fille Murorunkwere

Contributors: Joanita Mwiza
Ernest Dukuzumuremyi
Margret Mahoro
Grace Ntege Muhoza
Jessica Mbanda
Frank Kayitare

Kigali, November 2024

Table of Contents

Acronyms

AJPRODHO	Association de la Jeunesse pour la promotion des Droits de l'homme et de Développement [Youth Association for Human Rights Promotion and Development]
ANC	Antenatal care
CSO	Civil society organisation
DRC	Democratic Republic of Congo
ECD	Early childhood development
FBO	Faith-based organisation
FGD	focus group discussion
FRW	Franc Rwandais [Rwandan Franc]
GMO	Gender Monitoring Office
HDI	Health development initiative
ICF	International Coaching Federation
ICT	Information and communications technology
KII	Key informant interview
LODA	Local Administrative Entities Development Agency
MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINICT	Ministry of ICT and Innovation
MINIJUST	Ministry of Justice
MINUBUMWE	Ministry of National Unity and Civic Engagement
MOH	Ministry of Health
NCDA	National Child Development Agency
NCDP	National Early Childhood Development Programme
NCHR	National Commission for Human Rights
NGO	Non-governmental organisation
NISR	National Institute of Statistics of Rwanda
NPPA	National Public Prosecution Authority
OR	Odds ratio
PAR	Participatory action research
PTSD	Post-traumatic stress disorder
RBA	Rwanda Broadcasting Agency
RBC	Rwanda Biomedical Centre
REB	Rwanda Education Board
RGB	Rwanda Governance Board
RIB	Rwanda Investigation Bureau
RNEC	Rwanda National Ethics Committee
SPSS	Statistical package for social sciences
SRH	Sexual and reproductive health
STI	Sexually transmitted disease
SWOT	Strengths, weaknesses, opportunities and threats
TVET	Technical and vocational education and training
WHO	World Health Organization

List of figures

List of Tables

EXECUTIVE SUMMARY

1. Study background and objectives

This study on adolescent pregnancies in Rwanda explores a critical public health and social issue that greatly affects young women and their communities. Despite Rwanda's socio-economic progress, disparities persist, which especially affect adolescents and other vulnerable groups. Adolescent pregnancies remain frequent and pose numerous challenges to the wellbeing and future prospects of adolescent mothers and their families. The study identifies psychosocial factors that contribute to adolescent pregnancy, assesses their impact, and evaluates the effectiveness of current support systems. Its goal is to enhance support frameworks and propose evidence-based strategies that will reduce the number of adolescent pregnancies and improve the health of young mothers. The study was conducted by Interpeace Rwanda with financial support from the French Embassy in Rwanda.

The study was undertaken because effective interventions and policies are needed to mitigate the negative consequences of early childbearing. It aligns with Rwanda's goals to address socio-economic disparities and historical trauma, as outlined in relevant policy documents such as the National Strategy for Transformation (NST1) and the Vision 2050 framework, both of which aim to strengthen resilience and equity across communities. By drawing out the factors that cause adolescent pregnancy, the study hopes to empower vulnerable adolescents and foster a supportive environment for young mothers and their children, and so improve society more broadly.

2. Methodology

The study employed a structured methodology. It used a case-control design to assess adolescent pregnancies by comparing adolescent mothers aged 10 to 19 with adolescent non-mothers across Rwanda. The study used reports published in 2022 by the Gender Monitoring Office (GMO) and the Ministry of Gender and Family Promotion (MIGEPROF) to identify age groups significantly affected by early motherhood. The study aimed to describe comprehensively the challenges that young mothers face while considering demographic trends in adolescent pregnancy across the country. This age-focused approach generated insights into the different psychosocial impacts of pregnancy at various stages of adolescence, making it possible to design interventions tailored to specific needs.

The research team applied both quantitative and qualitative methodologies to enhance analysis of the data collected. Methods included surveys, focus group discussions (FGDs) with adolescent mothers, their parents and opinion leaders, and key informant interviews (KIIs) with local leaders, government officials (including MIGEPROF, MINEDUC, RBC...) and representatives of national NGOs and international organisations. To make sure that the study accurately represented social and economic contexts across the country, the team constructed a balanced sample of 1,174 individuals, including 587 adolescent mothers and 587 adolescent non-mothers, from five districts known to have high adolescent pregnancy rates (Nyagatare, Musanze, Rubavu, Gisagara and Gasabo), one from each of the country's five provinces, including the City of Kigali.

The team used both direct and indirect methods to gather data on the psychosocial factors that influence adolescent pregnancy and its effects. The study's analysis and final report highlighted key findings and set out actionable recommendations to improve support systems for adolescent mothers. By addressing identified

gaps, the study hopes to guide policy-making and community support initiatives in ways that will improve outcomes for adolescent mothers and their families throughout Rwanda.

The research team adopted a participatory action research (PAR) approach to make sure that the findings were aligned with national priorities and reflected the views of stakeholders from a range of sectors, including public bodies and national and international NGOs. It established a working group that met regularly to review the research process, including the concept note, methodology, data collection tools, preliminary findings, and draft report. To promote ownership of the initiative, the research process, findings and recommendations were presented during a national stakeholders' dialogue. This event enabled the research team to gather feedback and advice before it prepared the final report.

Ethical considerations

The study took steps to protect the wellbeing, dignity, and rights of all participants, particularly adolescent mothers and underage respondents. Given the sensitivity of adolescent pregnancy, the research team strictly observed ethical guidelines and obtained clearance from the Rwanda National Ethical Committee (RNEC) before it collected data. It sought the consent of parents or guardians and made sure that adolescents participated voluntarily. To manage emotional distress, the research team implemented comprehensive safety measures, including emergency protocols and training for researchers. These steps helped build trust, ensured participant protection, and enhanced the credibility and reliability of the study's findings.

Quality assurance and validity checks

The research team applied rigorous quality assurance and validity checks to safeguard the integrity of the study's findings. Research staff received training and an operational manual set out the project's standardised approach to data collection and its ethical norms. The team made sure that data quality was maintained by pre-testing survey instruments, continued supervision and regular team meetings. In the qualitative phase, member-checking and triangulation strategies were used to verify data accuracy. These robust measures ensured that findings were reliable and valid, providing a solid foundation for the study's recommendations.

3. Study findings

3.1 Demographics

The demographic analysis broke down adolescent mothers and adolescent non-mothers, across Rwandan districts, by age and education level. It revealed key trends that shaped the study's findings and can guide targeted interventions. The data were balanced in terms of geographical representation; Gasabo is slightly underrepresented due to high urban mobility. Older adolescents are more likely to become pregnant. Adolescent mothers tend to have a lower level of education than adolescent non-mothers. These insights highlight the need for interventions to prevent pregnancy and to support continued education, breaking cycles of socio-economic disadvantage. To tailor policies and programmes that will meet the population's specific needs, the demographic overview is essential.

3.2 Some aspects of sexual and reproductive health education and behaviours

This section of the report highlights disparities in the sexual and reproductive health (SRH) education received by adolescent mothers and adolescent non-mothers in Rwanda. Only 35.95% of adolescent mothers received SRH education before pregnancy, whereas 76.1% of adolescent non-mothers did so, emphasising that targeted interventions are needed to reach young women at risk. Schools were a key source of SRH information for school-going adolescent non-mothers; by contrast, adolescent mothers were less able to access school and SRH information and in some cases schools and SRH information were stigmatised.

Most adolescent mothers (71.04%) became sexually active between the ages of 15 and 17, and often lacked adequate SRH education or access to contraceptives; only 17.72% of adolescent non-mothers reported that they were in the same situation. Adolescent non-mothers showed a higher preference for condoms, indicating both that they had better access and were more aware. Cultural factors and cost also affected contraceptive choices. These findings show that SRH education and services need to be enhanced, and made available to out-of-school adolescents.

Taking these steps will empower young women, enable them to take informed decisions, reduce the number of adolescent pregnancies, and improve wellbeing.

3.3 Insights into the incidence and causes of adolescent pregnancy

This part of the study provided insights into adolescent pregnancy, including into the age of sexual partners, relationship dynamics, and marital status. Notably, 60.48% of adolescent mothers had slightly older partners (5 years or below), and 28.45% had much older partners (6 years or above), indicating potential power imbalances that could affect their decision-making autonomy in sexual and reproductive health. Half the adolescent mothers (50.60%) reported being in committed relationships, while 27.26% were in casual relationships. 6.64% reported that they had been victims of rape or defilement, highlighting the need for robust legal frameworks and support systems to protect young girls.

In terms of sexual partners' marital status, 83.65% of partners were single, which may influence the support available to adolescent mothers. The proportion of married partners (11.24% of cases) introduces additional social and legal challenges. These findings show that interventions are needed to address health, financial and legal protections, as well as societal attitudes that increase the vulnerability of adolescent mothers. A comprehensive approach that includes sexual education and accessible healthcare services is essential to manage the circumstances these young women face.

The study also revealed that 93.02% of adolescent mothers accessed antenatal care, confirming that health policies are being implemented effectively. However, 24.02% of adolescent mothers experienced complications during pregnancy or delivery, showing that healthcare interventions must be tailored to meet adolescent mothers' needs. The widespread use of hospital facilities for childbirth (98.13%) highlights Rwanda's success in promoting safe delivery practices and maternal health, though a small number of mothers did not receive adequate care. This is an area that could be further improved.

3.4 The prevalence of selected psychosocial variables among adolescent mothers and non-mother adolescents

The study reviewed a number of psychosocial variables, including parenting styles, participation in decision-making, peer pressure, and post-traumatic stress disorder (PTSD), depression, and anxiety. It found that their prevalence varied significantly between adolescent mothers and adolescent non-mothers.

- Only 59.54% of adolescent mothers experienced **authoritative and warm parenting**, compared to 81.69% of adolescent non-mothers, suggesting that supportive parenting provides an enabling environment for parent-child dialogues, including dialogues on sexual matters, and deters involvement in risky behaviours such as early sexual activity. Adolescent non-mothers also reported higher levels of structured parenting and autonomy, enhancing their sexual and reproductive decisions.

- **Authoritarian parenting (including verbal hostility and physical coercion)** was prevalent in both groups, reflecting cultural acceptance of harsh discipline, which has harmful psychological outcomes. Permissive parenting was more common among adolescent mothers, and was associated with less frequent communication and a higher incidence of unintended pregnancy.

- Before pregnancy, only 46% of adolescent mothers felt involved in **decisions that affected their lives**. By contrast, 55.54% of adolescent non-mothers were involved in such decisions, underscoring the importance of decision-making autonomy.

- **Peer pressure** had a stronger influence on adolescent mothers, affecting their attitudes to pregnancy.

- **Mental health challenges** were more pronounced among adolescent mothers. 32.71% showed symptoms of PTSD, double the rate of adolescent non-mothers. They also experienced higher rates of **depression and anxiety**: 30.15% reported moderate depression and 17.38% moderate anxiety.

These findings highlight the need for mental health interventions and improved parental engagement. Adolescents should also be empowered to take decisions. These elements make a crucial contribution to efforts to influence factors that cause adolescent pregnancy in Rwanda.

3.5 Psychosocial factors that contribute to adolescent pregnancy

- **Insufficient knowledge of sexual and reproductive health (SRH).** Adolescents who are well informed are 78.5% less likely to become pregnant. Unintended pregnancies are often due to lack of understanding of contraception and fertility, underscoring the need for enhanced SRH education programmes for youth.

- **Access to and use of contraceptives**. Adolescents who consider using contraceptives are 92.4% less likely to become pregnant. Failure to use contraceptives significantly increases the risk of adolescent pregnancy, highlighting the importance of promoting contraceptive awareness.

- **Parenting styles**. Warm, supportive parenting reduces the likelihood of pregnancy, while authoritarian or permissive parenting increases it. Parental engagement plays a key role in preventing adolescent pregnancies.

- **Peer pressure.** Adolescents who experience strong peer pressure are 14% more likely to become pregnant, emphasising the need to address social influences on adolescent behaviour.

- **Economic vulnerability.** Financial instability drives adolescents into relationships that meet their material needs but may result in pregnancy. Economic empowerment initiatives are crucial to mitigate these pressures.

- **Economic pressures on parents.** Many parents work long hours to sustain their families, which limits the time they have to supervise and communicate with their children. Adolescents in this situation are more prone to risky behaviour. Community programmes are needed to assist parents to manage their time and spend more time with their families.

- **Family conflicts.** Family instability, including marital disputes and poor parenting, push some adolescents to start risky external relationships in their search for love and stability.

- **Forced sexual intercourse**. Coercive sexual encounters cause a number of adolescent pregnancies, underlining the need for robust legal protections and social support systems.

- **Digital influences**. Misuse of digital tools can increase the risks of pregnancy. Steps should be taken to improve digital literacy and introduce protective measures.

- **Limited involvement of men and male adolescents.** Too few men and male adolescents accept their sexual health responsibilities. This increases the risks of pregnancy. Efforts need to be made to ensure that males share responsibility for contraception and sexual behaviour.

To address these challenges, it is essential to adopt a holistic approach, which should involve SRH education, economic empowerment, parental engagement, legal protection, and digital literacy. Community-driven, culturally sensitive interventions play a crucial role in reducing the number of adolescent pregnancies in Rwanda.

3.6 The psychosocial effects of pregnancy on adolescent mothers

- The analysis shows that adolescent pregnancy has a significant psychosocial impact on young mothers. In particular, it increases the risks of PTSD, depression and anxiety.

- Adolescent mothers are over three times more likely than adolescent non-mothers to experience PTSD, and twice as likely to experience moderate depression. They are also more anxious. These results show that young mothers need targeted mental health interventions.

- Negative reactions by parents and relatives, including anger (71.21%) and disappointment (43.78%), add to the stresses young mothers face.

- Expulsion from home. 15.33% of young mothers are forced to leave home, which clearly worsens their situation. Supportive responses are less common (25.21%), but help to mitigate the situation of young mothers.

- Emotional distress is high. 63.03% of adolescent mothers reported that they had experienced depression, and 53.49% that they had experienced anxiety, as a result of their family's reactions.

- Feelings of judgment and guilt. 41.23% of young mothers felt judged and 37.31% felt guilty, reflecting the social stigma they experience. Interventions are needed to encourage family support and change societal attitudes.

- Cultural stigma and family blame increase the emotional distress of young mothers. Psychological services and family counselling need to address these issues.

- Unsafe abortions, often prompted by stigma, highlight the need for accessible reproductive health services and comprehensive sexual education.

- The psychological burden that young mothers carry sometimes causes them to have suicidal thoughts. Strong support networks and appropriate mental health interventions are required to address this danger.

- Economic hardship and social isolation push some young mothers towards prostitution. Robust support systems are needed to address this risk.

- Prenatal and postnatal complications are concerns. Some adolescent mothers avoid antenatal care due to stigma or family pressures.

- Adolescent pregnancy frequently disrupts education. Most young mothers drop out of school; others struggle to resume schooling due to stigma, family conflict, or lack of childcare. Comprehensive interventions are required to enable young mothers to continue or resume their education and increase their economic stability.

To enable adolescent mothers to thrive and contribute positively to their communities, despite the challenges they face, it is vital to take a **multi-sectoral approach** that integrates health, education, and social services.

3.7 The psychosocial effects of adolescent pregnancy on the families of adolescent mothers

Adolescent pregnancy profoundly affects young mothers but also their entire families, which require comprehensive support.

- Unexpected adolescent pregnancies often cause families significant psychological distress which stigma amplifies. Parents and relatives can experience depression and anxiety.

- Adolescent pregnancies can trigger marital discord. Parents, typically fathers, often blame their partner for failing to provide supervision or moral guidance, leading to marital conflict that undermines family stability.

- Relationships between parents and pregnant adolescents often become strained. Parental anger and disappointment can create conflict and disrupt family harmony.

- Community stigma is also harmful. Judgment and social isolation can cause social withdrawal or aggression, further isolating the family.

These potential outcomes highlight that it is important to adopt a **comprehensive approach** that integrates educational, psychological, social, and economic interventions. Comprehensive support systems are essential to improve the wellbeing of adolescent mothers and their families, and promote a healthier and more stable social environment.

3.8 The effectiveness of psychosocial support systems and adolescent mothers' awareness and use of them.

- The research found a significant gap between the availability of support systems and their actual use, highlighting issues of access and effectiveness.

- Local health centres are the most recognised source of support. 47.19% of adolescent mothers and 50.30% of adolescent non-mothers are aware of them. However, adolescent non-mothers reported higher awareness of parental support (30%) compared to mothers (19.93%), suggesting that family ties are stronger among adolescent non-mothers.

- Specialised mental health services. Young mothers were not well informed about private psychotherapy and community healing spaces, and do not use them much, for reasons of cost as well as lack of awareness. Compared with adolescent non-mothers, adolescent mothers were less involved in broader community initiatives.

- Alarmingly, around 6% of adolescent mothers and over 7% of adolescent non-mothers reported that they knew of no sources of support, underscoring the need for better mental health education and outreach.

- Use rates are low. 84.16% of adolescent mothers and 87.90% of adolescent non-mothers did not seek psychosocial support in the past year. Barriers for adolescent mothers include stigma, logistical challenges, and lack of services that match their needs.

- Local health centres and community health workers are key resources, though adolescent mothers reported that they received less family support than adolescent non-mothers. Both groups underuse professional psychological services due to stigma and their cost.

- Perceived lack of need is a key reason for not seeking support. 90.31% of adolescent non-mothers and 81.78% of adolescent mothers took the view that they did not need help. Mothers who have unplanned pregnancies are deterred by cultural stigma. Affordability and access are also barriers to seeking help.

These findings show that targeted interventions are required to improve access to psychosocial support and its effectiveness. Enhanced mental health literacy, integrated services, and destigmatised mental health care are crucial elements of a strategy to support the wellbeing of adolescent mothers and adolescent non-mothers.

3.9 The effectiveness of psychosocial support systems in addressing adolescent mothers' needs.

- With respect to the effectiveness of psychosocial support for adolescent mothers, there are critical gaps between the resources that are available and their actual use. This shows that more needs to be done to improve the psychological and emotional wellbeing of young mothers.

- While over 47% of mothers recognise that local health centres are a key source of support, few make use of them. There are misperceptions about the services they offer and barriers to access. These services must become more accessible and responsive to adolescent mothers' specific needs.

- Data on services accessed by adolescent mothers and non-mother adolescents who seek psychosocial support show distinct patterns. Psychological counselling was widely accessed by both groups (82.80%

of the adolescent mothers and 84.50% of the adolescent non-mothers who sought help), highlighting the relevance of mental health support. Material support was fairly balanced, while slightly more medicines were provided to mothers. More adolescent mothers received referrals (13.98%), possibly reflecting their more complex needs. Legal support was minimal (3.23% for adolescent mothers), though this figure probably underestimates the assistance that specialised legal providers actually provide. A more holistic approach is needed to address these broader challenges.

- Satisfaction with services varied. 53.76% of adolescent mothers and 63.38% of adolescent non-mothers reported that they were highly satisfied. However, 39.78% of adolescent mothers were only moderately satisfied. Areas of dissatisfaction included stigma, affordability, and confidentiality. These are areas in which improvements can be made.

- Stigma, cost, and lack of information prevent many adolescent mothers from using services. This underscores the need for awareness campaigns and community-based programmes that address their specific needs.

In July 2024, Interpeace organised a stakeholders' workshop to run a SWOT (strengths, weaknesses, opportunities, and threats) analysis of preventive and support systems for adolescent mothers in Rwanda. The analysis revealed that current systems, which include community outreach, traditional family gatherings, school health clubs, and peer-to-peer support networks, raise awareness and provide essential services. Key strengths identified included improved policy literacy, government commitment, and accessible reporting mechanisms that foster community engagement. Weaknesses identified included limited funds, poor awareness of laws, social stigma, and lack of follow-up care. Opportunities for improvement that were identified included adoption of new laws and expansion of comprehensive support models such as the Isange One Stop Centre. Threats that were identified included cultural norms and economic challenges, which complicate efforts to promote reproductive health and highlight that a more coordinated approach is required to meet the needs of this vulnerable population.

Overall, to meet the needs of adolescent mothers, Rwanda's psychosocial support systems need to be improved significantly. It is crucial to enhance their **accessibility**, **relevance**, and **sensitivity** through community engagement, stigma reduction, and outreach efforts. Strengthening **family support** through education and counselling can amplify external interventions and create a supportive environment for the empowerment and integration of adolescent mothers.

The research calls for a unified response by the **health, education, social service** and **economic sectors** to address the causes and consequences of adolescent pregnancies. Adoption of a **holistic approach** can create a supportive environment that improves the health of adolescent mothers in Rwanda, and also empowers them and increases their social integration. Strategies to prevent adolescent pregnancies and support pregnant adolescents and young mothers are outlined below, in three tables drawn from the main report (Tables 39, 40 and 41).

Table 39: Strategies to prevent adolescent pregnancy

Dimension	Issue	Action	Responsible institutions
Health/education	Adolescents lack knowledge of sexual and reproductive health.	Fully implement comprehensive sexual and reproductive health education in schools, families, and communities.	MINEDUC, MoH, RBC, CSOs, local leaders.
Health	Contraception is not accessible, is not used, or is not understood.	Strengthen efforts to change social attitudes and norms that hinder sexual and reproductive health education.	Ministry of Health, RBC, CSOs, healthcare providers, FBOs.
		Campaign in favour of contraception. Provide free or subsidised contraceptives.	Ministry of Health, RBC, CSOs, healthcare providers.
Education	Teachers lack training in gender-responsive pedagogy and sexual and reproductive health.	• **Implement a phased, continuous training programme** for teachers on gender-responsive pedagogy and sexual and reproductive health. • Prioritise areas with the greatest need.	MINEDUC, REB.
		• **Establish a monitoring and support system** to ensure that schools consistently teach pupils about gender-responsiveness and sexual health. • Offer teachers regular assessments and feedback loops.	MINEDUC and REB in collaboration with local district education offices.
Family	Parenting styles.	• Promote positive parenting techniques. Strengthen and extend positive parenting workshops. • Promote positive masculinity and encourage men to reduce adolescent pregnancy rates.	MIGEPROF, CSOs, NCDA, MINIYOUTH.
Family/community	GBV responses focus on victims and overlook perpetrator accountability. Social stigma, financial dependence, and biased media reporting shield offenders and perpetuate victim-blaming.	• Prosecute men who commit GBV offences against adolescent women. • Fully implement the sexual offender registry to deter GBV crimes and increase public accountability.	RIB, National Public Prosecution Authority (NPPA), Supreme Court.
		Enforce ethical media guidelines to eliminate victim-blaming and promote responsible GBV reporting.	MIGEPROF, Rwanda Media Commission, Rwanda Governance Board (RGB), National Commission for Human Rights (NCHR).
		Run family-level awareness campaigns to encourage people to report gender-based violence and reduce social tolerance of it.	MIGEPROF, RIB, and CSOs.

Dimension	Issue	Action	Responsible institutions
	Insufficient male involvement in adolescent pregnancy prevention.	• Deliver comprehensive sexual and reproductive health (SRH) education tailored specifically for men and male adolescents, focusing on promoting responsible behaviour, fostering positive masculinity, and encouraging their active role in preventing adolescent pregnancies. • Enhance positive masculine behaviour and encourage men to act responsibly to reduce unintended pregnancies.	MIGEPROF, Ministry of Health, RBC, CSOs.
Family/community	Peer pressure.	Run community, family, and school-based programmes to teach adolescents about peer influence and sound decision-making.	Ministry of Youth, youth organisations, schools, CSOs, MIGEPROF, MINEDUC.
		Develop programmes that encourage families, schools, communities, churches and other social groups to discuss sexual and reproductive health.	Ministry of Youth, RBC, youth organisations, schools, CSOs, RGB.
	Parents do not supervise or talk to their children enough because they work very long hours.	• Encourage employers to allow parents to spend more time at home. • Encourage the formation of community groups to advise and support parents. • Encourage parents to stay at home with their children at least once a week, making time to eat and talk together. • Encourage families to spend time and relax with other families.	Ministry of Public Service and Labor, MIGEPROF, businesses, NGOs.
	Intrafamily conflicts.	• Provide family counselling services to manage marital disputes and improve family relationships. • Train community-based family counsellors to run family healing spaces.	MIGEPROF, MINALOC, NGOs, FBOs, local leaders, development partners.
	Economic hardship.	• Strengthen social protection programmes to improve the social and economic condition of families that face economic hardship. • Mobilise additional resources; take steps to reach the most disadvantaged households; design interventions that enable families to graduate swiftly out of support programmes. • Use the social registry to identify and target families that are most in need.	MINALOC, Ministry of Public Service and Labor, CSOs, financial institutions.
		• Reinforce programmes for young people that teach community-based skills and provide job training and financial literacy. • Target girls and vulnerable communities. • Provide start-up loans.	Ministry of Public Service and Labor, CSOs, financial institutions, MINALOC, MINECOFIN.

Dimension	Issue	Action	Responsible institutions
Legal	Forced sexual intercourse.	Raise community awareness of child defilement and rape. Make the public aware that both are criminal offences.	RIB, judiciary, CSOs.
		Prosecute individuals who commit crimes of child defilement, or forced sexual intercourse, as well as individuals who cover up such crimes.	RIB, National Public Prosecution Authority, judiciary, legal aid organisations.
Media/digital	Harmful influences of digital and social media.	• Conduct digital literacy campaigns; run digital literacy workshops in schools and for parents and the community with the aim of reducing risky behaviour. • Monitor and remove harmful online content.	Ministry of ICT, schools, parents, telecommunications companies.
Cross-sector	Scattered and uncoordinated interventions.	Strengthen cross-sectoral collaboration between ministries, local leaders, and community organisations to ensure they adopt a unified approach to preventing adolescent pregnancy. • Create a task force that brings together MIGEPROF, MINEDUC, MoH, Ministry of Justice, and MINALOC, alongside key CSOs and community organisations, to develop and monitor policies that prevent adolescent pregnancy and meet the needs of adolescent mothers. • Establish monitoring and evaluation mechanisms to track the progress of efforts to reduce adolescent pregnancy and support adolescent mothers.	All relevant ministries, local leaders, CSOs.

Table 40: Strategies to mitigate the impact of adolescent pregnancy and early motherhood and resolve issues in support systems

Dimension	Issue	Action	Responsible institutions
Health	PTSD, depression, anxiety, suicide risk, and risky behaviours.	Design and provide a comprehensive mental health services package that specifically targets the needs of adolescent mothers. Decentralise mental health services to health centres.	Ministry of Health in collaboration with CSOs.
	Prenatal and postnatal health complications.	• Put in place a mechanism that gives adolescent mothers priority access to prenatal and postnatal care. • Reduce and remove obstacles (such as cost and stigma) that impede adolescent mothers from accessing healthcare services they need. • Waive the requirement that pregnant adolescents must attend prenatal and post-natal care with their partner.[1]	Ministry of Health.
	Unprofessional behaviour of medical staff.	Train healthcare providers to receive and treat adolescents in a manner that is supportive and non-discriminatory.	Ministry of Health, RBC, health care facilities.
		Implement a monitoring system to ensure that all health facilities comply with the above policy.	Ministry of Health, RBC, health care facilities.
Health (psycho-education, psychosocial support)	Abusive and stigmatising reactions of parents, relatives and society.	• Run community-based programmes to educate families about the impact on families of abusive and stigmatising behaviour. Include discussion of family responses to adolescent pregnancy. • Offer mediation services to improve family relationships.	MIGEPROF, CSOs.
	Emotional distress as a result of family reactions.	Provide support groups and counselling that will help the families of adolescent mothers to show understanding and give them support.	MOH(RBC) in collaboration with social services, CSOs, FBOs.
	Cultural stigmas and family condemnation.	Run national campaigns to reduce the stigma associated with adolescent pregnancy and promote inclusive community practices.	MIGEPROF, media outlets.
	Unsafe abortion.	• Increase access to reproductive health services, especially for adolescent women. • Provide comprehensive education on sexual and reproductive health, including reproductive choices. • Disseminate legal and sexual information on unsafe abortion and its risks.	MoH, Education Department, legal aid providers.

1 In Rwanda, pregnant women are required to attend pre- and postnatal visits at health centres with their partner. This requirement is particularly impractical for adolescents and cases where pregnancy is due to abuse. Some participants noted that the policy disproportionately impacts pregnant adolescents, who are less able to access essential healthcare.

Dimension	Issue	Action	Responsible institutions
Economic	Prostitution due to economic hardship and family rejection.	• Create vocational training, microfinance and other economic opportunities for adolescent mothers, to reduce their economic hardship and the risk that they may resort to prostitution to survive. • Extend social protection programmes to vulnerable families.	MINALOC (LODA) and NCDA in collaboration with NGOs.
	Exclusion of adolescent mothers from services that can assist them.	Take steps to make it easier for adolescent mothers to access social protection programmes designed to help them.	NCDA, LODA.
Education (formal)	Educational disruption.	**Provide scholarships and financial support to adolescent mothers who want to continue or resume their education.**	MINEDUC, MIGEPROF, CSOs, FBOs and development partners.
		To assist young mothers to pursue their education, ***e*xpand early childhood development (ECD) services and their opening hours.**	MINEDUC, MIGEPROF and National Early Childhood Development Programme (NCDP).
		Develop a mentorship and support programme that pairs adolescent mothers with trained counsellors or peer mentors.	MIGEPROF, REB, CSOs, FBOs.
		Run community awareness campaigns to reduce the stigma associated with adolescent motherhood.	MIGEPROF, MINEDUC, Rwanda Broadcasting Agency (RBA), CSOs and FBOs.
Legal	Reluctance to report child abuse.	• Develop and enforce mechanisms that protect victims of child abuse. • Reward reporting of abuse. Take steps to ensure that people can report abuse without fear of retribution or financial loss.	MIGEPROF and MINIJUST in collaboration with CSOs, legal aid institutions and justice organisations.
		Implement legal and rights educational programmes that inform adolescents and their families about their rights and the support available to them.	Ministry of Justice, RIB, CSOs specialising in children's and women's rights.
	Legal and bureaucratic barriers.	• Make legal and medical services more accessible to adolescents and adolescent mothers by extending the Isange One Stop Centres to local health centres. • Simplify the legal process for reporting and addressing adolescent abuse cases. • Ensure cases of defilement are prosecuted in a way that includes both criminal and civil actions as required by law.	Ministry of Justice, MoH, RBC, RIB.

Dimension	Issue	Action	Responsible institutions
Cross-sector	Scattered and uncoordinated interventions.	• Strengthen cross-sectoral collaboration between ministries, local leaders, and community organisations to ensure they adopt a unified and comprehensive approach to supporting adolescent mothers. o Create a task force that brings together MIGEPROF, MINEDUC, MoH, the Ministry of Justice, and MINALOC, alongside key NGOs and community organisations, to develop and monitor policies that prevent adolescent pregnancy and meet the needs of adolescent mothers. o Establish monitoring and evaluation frameworks to track the progress of efforts to reduce adolescent pregnancy and improve support for adolescent mothers.	All relevant ministries, local leaders, NGOs.

Table 41: Strategies to mitigate the impact of adolescent pregnancies on young mothers' families

Dimension	Issue	Action	Responsible institutions
Health	Psychological distress caused by unexpected pregnancy.	• Make psychological support available to help families and adolescent mothers manage the initial shock of pregnancy and subsequent phases. Include counselling services and stress management workshops. • Offer adolescent mothers substantive psychosocial support over a period (not just short term first aid).	Ministry of Health, RBC, community mental health services, NGOs.
Family/community	Marital discord triggered by pregnancy.	• Put family mediation and counselling programmes in place to address family conflicts, and enable parents to cooperate as they manage adolescent pregnancy. • Create family healing spaces where family members can participate in healing and dialogue facilitated by trained community-based counsellors.	MIGEPROF, MINALOC, NGOs, local leaders.

Dimension	Issue	Action	Responsible institutions
Family/community	Strained parent-child relationships.	• Launch initiatives to teach parents positive parenting and supportive parenting practices. Run communication workshops that will help families to communicate and sustain healthy relationships during crises. • Set up intergenerational family dialogue spaces that encourage positive communications between parents and their children.	Ministry of Education, NGOs, MIGEPROF.
	Community stigma and isolation.	• Promote community awareness programmes that address the stigma associated with adolescent pregnancy and promote inclusion. Focus on empathy and building community support. • Disseminate and raise public awareness of gender-based violence and violence against children, and the importance of combating both, as well as supporting victim reintegration.	MIGEPROF, local leaders.
Cross-sector	Scattered and uncoordinated interventions.	• Strengthen cross-sectoral collaboration between ministries, local leaders, and community organisations to ensure that they adopt a unified approach to adolescent pregnancy and its impact on families.	All relevant ministries, local leaders, NGOs.

Note. Interventions to prevent adolescent pregnancy and support adolescent mothers must adopt a holistic and age-specific approach that integrates psychological, social, legal, and economic dimensions of policy in order to provide reproductive education, mental and social support, legal protection, and economic opportunities, while fostering inclusion and empowerment.

1. INTRODUCTION

Despite its impressive and progressive recovery from the genocide against the Tutsi and its aftermath, contemporary Rwandan society faces several significant policy challenges. Among these, adolescent pregnancy stands out as a major societal concern that affects the wellbeing of adolescents and their families. This report describes a study sponsored by Interpeace Rwanda and financially supported by the French Embassy in Rwanda. It investigated adolescent pregnancy in Rwanda, focusing on the psychosocial factors that influence adolescents' reproductive health decisions and the effects of pregnancy on adolescent mothers and their families. The report contains an introduction, a description of the context, a problem statement, a literature review, the objectives and methodology of the research, ethical considerations, findings and analysis, recommendations, and a conclusion. Overall, it provides a thorough review of adolescent pregnancy in Rwanda, including evidence-based insights that can guide interventions and policy measures.

1.1. The context

Rwanda's complex socio-cultural landscape is marked by a history of profound trauma, as well as resilience and significant reconstruction. Despite impressive efforts made by the Government and development stakeholders, socio-economic disparities exacerbated by the 1994 genocide against the Tutsi persist, and some disadvantaged populations (notably the poor, people with disabilities, and remote rural communities) still face challenges in accessing economic opportunities and a decent standard of education and healthcare.

In this context, adolescent pregnancy is a significant concern, which reflects broader social dynamics and vulnerabilities. Traditional gender roles and societal expectations put pressure on young people to marry young and start families, and young people also have limited access to sexual education and reproductive health services.

Moreover, the consequences of adolescent pregnancy extend beyond the individual. They affect families, communities, and the nation as a whole. Pregnant adolescents often face social stigma and discrimination, which can hinder their access to support services and exacerbate feelings of isolation and shame. Early parenthood disrupts education and causes economic hardship, which can perpetuate cycles of poverty and marginalisation, undermining efforts to achieve sustainable development and social justice in Rwanda.

To understand the causes and effects of adolescent pregnancy in contemporary Rwanda, the research team adopted a multidimensional approach that considered the interactions of trauma, socio-cultural dynamics, and structural inequality. This enabled the team to draw out the underlying drivers and consequences of adolescent pregnancy, and identify effective interventions that will improve the wellbeing of adolescent mothers and also contribute to broader goals by promoting the health, dignity, and empowerment of Rwanda's youth population.

1.2. Problem statement

The aftermath of the genocide against the Tutsi has left indelible marks on the nation's social, cultural, and psychological landscape. While efforts have been made to rebuild and heal the wounds of the past, the legacy of the genocide continues to shape the experiences and trajectories of Rwandan youth, not least in the areas of reproductive health and sexuality.

Adolescent pregnancy is a pressing concern that reflects deeper societal challenges and vulnerabilities. The psychological toll of the genocide, including trauma, loss, and displacement, has profoundly influenced the mental health of Rwandan adolescents and their ability to cope. Many young people grapple with unresolved grief, anxiety, and depression, which affect their decision-making and resilience.

The socio-cultural context in contemporary Rwanda adds a further layer of complexity. Traditional norms and values intersect with modern influences, shaping adolescent perceptions of gender roles, sexuality, and relationships. Patriarchal structures limit girls' agency and autonomy, while societal expectations of marriage and parenthood exert pressure on young couples to start families prematurely.

According to the United Nations Population Fund (n.d.), "early childbearing, high fertility rates and inadequate access to maternal health services are the main factors that contribute to the high number of maternal deaths among young women in Africa".[2] In a report on Rwanda published in 2021, the National Institute of Statistics of Rwanda (NISR), the Ministry of Health (MOH), and ICF International found that adolescent pregnancy is "a major health concern because of its association with higher morbidity and mortality for both the mother and the child … Childbearing during adolescence is known to have adverse social consequences, particularly regarding educational attainment, as women who become mothers in their teens are more likely to drop out of school … 5% of women aged 15-19 have begun childbearing; 4% have given birth, and 1% are pregnant with their first child" (NISR, MOH, ICF, 2021, p. 77).

According to official statistics, 17,849 underage girls in Rwanda fell pregnant in 2016. The number fell slightly to 17,337 in 2017 but jumped to 19,832 in 2018. Between January and August 2019, 15,696 teen pregnancies were recorded, an average of 1,962 a month. Based on this, an estimated 23,544 children were born to adolescent mothers in 2019 (Interpeace, 2021, p. 47).

The Gender Monitoring Office (GMO) suggested that a total of 24,472 teenagers gave birth in Rwanda's 30 districts between January and December 2022.[3]

It is worth noting that most teenage pregnancies occur in poorer families. In Rwanda, "teenage childbearing is less common in the wealthiest households: 3% of women in the highest wealth quintile have begun childbearing, as compared with 8% of those in the lowest quintile" (NISR, MOH, ICF, 2021, p. 78).

Adolescent pregnancies have cascading effects on individuals and society at large. They not only jeopardise the health and wellbeing of young mothers and their children, but perpetuate cycles of poverty and related vulnerabilities. However, while many studies have examined the causes and impact of adolescent pregnancy in Rwanda, to the best of our knowledge few have explored its psychological dimensions. It is therefore important to understand the degree to which psychosocial issues influence the reproductive decisions of young girls, as well as the psychosocial repercussions of adolescent pregnancy.

The research described here captures the voices and experiences of adolescent mothers and their families, to shed light on their lived realities and aspirations. Policymakers, healthcare providers and community stakeholders will not meet the unique needs of young mothers and their children, or develop interventions and support services that effectively promote their wellbeing and resilience, or mitigate the negative consequences of early childbearing on individuals and communities, until they understand the psychosocial dynamics and effects of adolescent pregnancy.

Ultimately, by unpacking the psychological root causes of adolescent pregnancy as well as its adverse effects,

2 https://esaro.unfpa.org/en/topics/adolescent-pregnancy#:~:text=Early%20childbearing%2C%20high%20fertility %20rates women%2020%20years%20and%20above.

3 eenage deliveries, January-June 2022 and July-December 2022 (disaggregated by district). Data from Gender Monitoring Office (GMO), Rwanda.

this research contributes to the broader goal of promoting the health, dignity, and resilience of Rwanda's youth. Working collaboratively, policymakers, healthcare providers, civil society organisations and communities can find sustainable solutions that will create a more equitable and inclusive future for all Rwandan adolescents.

1.3. The study's objectives

The central aim of the study was to fill gaps in knowledge about the psychosocial causes and effects of adolescent pregnancy in Rwanda and contribute to the development of evidence-based strategies for addressing this pressing public health concern. The research team sought to amplify the voices of adolescent mothers and their families, shed light on their lived experiences, and advocate for their rights and wellbeing in Rwandan society.

Specifically, the study aimed to:

1. Identify psychosocial factors that contribute to adolescent pregnancy in Rwanda.
2. Examine the effects of adolescent pregnancy on the mental health and wellbeing of adolescent mothers.
3. Explore the psychosocial consequences of adolescent pregnancy on the families of adolescent mothers.
4. Assess adolescent mothers' awareness and use of psychosocial support systems.
5. Assess how effectively psychosocial support models address adolescent mothers' needs.

Propose actionable recommendations that will curb adolescent pregnancy and provide more effective and holistic psychosocial support for adolescent mothers.

2. A brief literature review and the conceptual framework

This section examines the factors that drive adolescent pregnancy worldwide, and its effects, drawing on available literature. Adolescent pregnancy is a global public health challenge, which affects young mothers and their children. To develop effective interventions, it is crucial to understand its many causes. While socioeconomic factors, including poverty and limited education opportunities, play a central role, the incidence of adolescent pregnancy is also influenced by interpersonal, community, and sociocultural factors. Unfortunately, most research on this issue, particularly in Rwanda, has lacked control groups and has primarily been quantitative. Deeper studies of psychosocial influences are needed. This review emphasises the importance of adopting mixed methods and case-control designs in future research, to generate an evidence base for programmes that seek to mitigate the adverse effects of early motherhood.

2.1 Factors that drive adolescent pregnancy worldwide

Adolescent pregnancy remains a significant global public health challenge, with profound implications for the health and welfare of young mothers and their children. Efforts to devise effective interventions and policies need to be based on a sound understanding of the many factors that contribute to it. This brief literature review explores that question.

Socioeconomic factors are a primary driver of adolescent pregnancy. Poverty is a particularly important factor. Economic deprivation impedes access to education, healthcare, and livelihood opportunities, and amplifies adolescents' vulnerability to early sexual initiation and unintended pregnancy. Second, girls often have more limited educational opportunities, which hinders their ability to acquire the information they need to make informed decisions about their sexual and reproductive health. Third, adolescents who experience high levels of unemployment and economic insecurity (and also the families of those adolescents) may perceive that early parenthood is a path to social status or financial stability. (See Yakubu and Salisu, 2018; Bitew, Akalu, Belsti et al, 2023; Senkyire et al, 2022; Aluga and Okolie, 2021; Oke, 2010.)

Individual and interpersonal factors are also significant factors. Adolescents grappling with low self-esteem or body image issues may adopt risky sexual behaviours to earn validation or acceptance. Peer pressure and peer social norms can influence adolescents' sexual behaviour and attitudes to contraception. Where parents are less involved, or do not communicate well, their adolescent children are more likely to engage in unprotected sex and fall pregnant, underscoring the pivotal role of positive parent-child communication in averting adolescent pregnancies. (See Qolesa, 2017; Black and DeBlassie, 1985; Aluga and Okolie, 2021; Alukagberie, Elmusharaf, Ibrahim et al, 2023; Malunga, Sangong, Saah et al, 2023.)

Psychological factors also shape adolescents' reproductive behaviour and decisions. Mental ill-health (conditions such as depression, anxiety, and stress) is particularly critical. Adolescents who experience mental health challenges may engage in risky sexual behaviours as a coping mechanism or may not use contraception. Lack of self-esteem and body image issues can also contribute to early pregnancy, because adolescents may seek validation or acceptance through intimate relationships. Peer pressure and social influences are additional factors, since adolescents may feel pressured to conform to perceived expectations of sexual activity and early parenthood. Additionally, family dynamics and the quality of parent-child relationships can influence adolescents' psychological wellbeing and the likelihood that they will engage in unprotected sex. It is crucial to

understand and address such psychological factors when developing interventions to reduce teenage pregnancy and promote the overall wellbeing of adolescents. (See Keddie, 1992; Agba, Mathias and Blessing, 2022.)

Community and sociocultural factors that influence the incidence of adolescent pregnancy include gender inequality, traditional gender norms, cultural beliefs, and inadequate access to sexual and reproductive health services. Societal expectations of girls' chastity and motherhood and other differences in the treatment of gender curtail girls' autonomy and decision-making in reproductive matters. Cultural attitudes and practices with respect to sexuality, marriage, and fertility may stigmatise premarital sex and contraception, deterring adolescents from making use of reproductive health services. If girls cannot readily access confidential, youth-friendly sexual and reproductive health services, adolescent pregnancies are likely to increase. All these factors underscore that comprehensive, multi-sectoral approaches are required to address the causes of adolescent pregnancy. (See Amoadu, Ansah, Assopiah et al., 2022; Black and DeBlassie, 1985; Aluga and Okolie, 2021; Alukagberie, Elmusharaf, Ibrahim et al, 2023; Malunga, Sangong, Saah et al, 2023; Dubik, Aniteye, Solina, 2022; Brahmbhatt, Kågesten et al, 2014.)

Overall, the incidence of adolescent pregnancy is influenced by an array of socioeconomic, individual, interpersonal, community, and sociocultural factors. To have an effect, holistic strategies need to empower young people, promote gender equality, and enhance access to education, healthcare, and services. By addressing the underlying determinants of adolescent pregnancy, policymakers, healthcare providers, and communities can curtail early childbearing and foster the health and wellbeing of adolescents globally.

2.2 Adolescent pregnancy in Rwanda

A substantial body of scholarship describes the factors that drive adolescent pregnancy in Rwanda. Numerous socio-cultural, economic, and systemic factors shape the reproductive decisions of young women across the country. Traditional gender norms and societal expectations play a significant role. These and ideas of defilement often pressure girls into early marriage and motherhood. Patriarchal structures that limit girls' autonomy and decision-making power also perpetuate cycles of early pregnancy. Economic disparities, especially poverty and the absence of opportunities, cause some girls to believe that marriage and childbirth are routes to economic survival or social advancement. Additionally, educational disparities, particularly in rural areas, increase the vulnerability of girls who have limited access to schooling and as a result are ill-equipped to make informed reproductive health choices. (See Kabera Bazubagira and Umumararungu, 2023; Kagabika and Irabona, 2021; Dukunde and Niyizamwiyitira, 2023; Girl Effect Rwanda, 2020.)

The absence of comprehensive sexual education further compounds the problem. Many adolescents lack access to accurate information about reproductive health and contraception and are therefore at risk of unintended pregnancy, highlighting the need for improved education in this area. Moreover, gender and sexual violence and sexual exploitation, including rape and transactional sex, contribute to the high prevalence of adolescent pregnancies. Coerced sex and early initiation into sexual activity underscore the importance of addressing issues of gender inequality and violence against women. (See Kabera Bazubagira and Umumararungu, 2023; Hakizimana, Logan and Wong, 2019 ; Ajprodho Jijukirwa (Youth Association for Development and Human Rights Promotion, 2020; Girl Effect Rwanda, 2020.)

Challenges in accessing reproductive health services are also a contributory factor. Stigma, cultural beliefs, and weaknesses in the healthcare system hinder adolescents' ability to obtain contraception and other essential services. Despite efforts to improve access to family planning, many young people still find it difficult to obtain contraceptives, highlighting the need for comprehensive reform in this area of healthcare. (See Dukunde and Niyizamwiyitira, 2023; Girl Effect Rwanda, 2020.)

2.3 The effects of adolescent pregnancy in Rwanda

Adolescent pregnancy affects the individuals concerned, their families, and society as a whole. One major consequence is that young girls drop out of education, perpetuating a cycle of poverty and limiting girls' ability to empower themselves. Many girls who become pregnant during adolescence are forced to halt their education as a result of societal stigma, lack of support, and the challenge of balancing motherhood and study. This outcome increases inequality and hinders efforts to promote gender equality and socioeconomic development. (See Girl Effect Rwanda, 2020.)

Adolescent mothers in Rwanda also encounter specific health risks during pregnancy and childbirth because their bodies are not fully developed. The fact that not all adolescent women have access to good healthcare increases the rate of maternal and infant mortality. Teenage mothers are more susceptible to complications during childbirth, including obstetric fistulas and postpartum depression, which can have long-lasting physical and psychological effects. Such challenges affect the wellbeing of adolescent mothers but also put their families under emotional and financial strain as they seek to obtain medical care and support. (See Girl Effect Rwanda, 2020).

Adolescent pregnancies can perpetuate cycles of poverty and vulnerability, particularly in Rwanda, where rebuilding and development efforts are ongoing. Teenage mothers often face economic hardship as they struggle to provide for themselves and their children without adequate education or skills. This can increase their reliance on social welfare programmes and charitable organisations, putting more strain on already stretched resources. Additionally, children born to adolescent mothers are more likely to experience poverty, poor health, and limited access to education. These outcomes tend to perpetuate intergenerational cycles of disadvantage. To break these cycles and promote sustainable development, strategies to reduce adolescent pregnancy in Rwanda need to address education and healthcare needs, economic empowerment, and social support systems. (See Girl Effect Rwanda, 2020; Umumararungu and Bazubagira, 2023.)

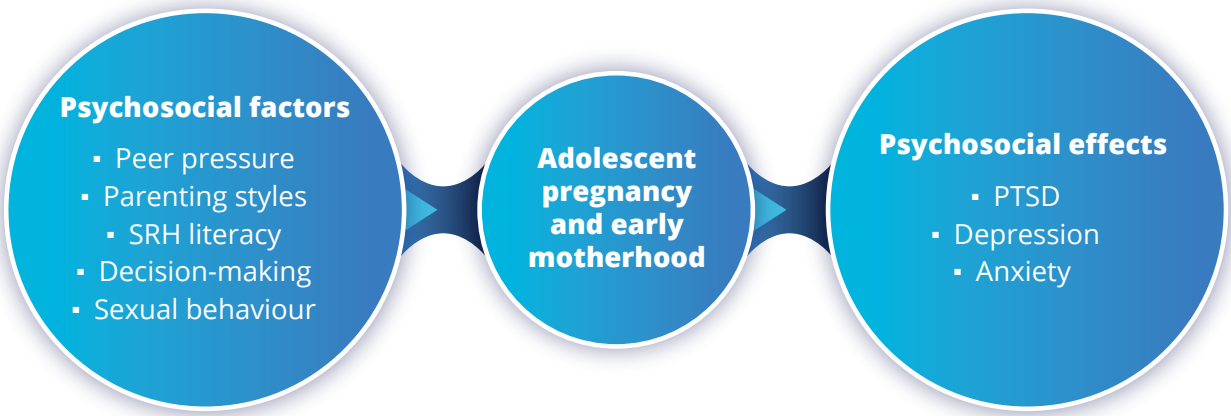
Adolescent pregnancies strain family dynamics and resources. Families may struggle to provide the support and care that young mothers and their children need, particularly if they are already coping with the effects of the genocide or face economic hardship. In some cases, families stigmatise and reject adolescent mothers, worsening their vulnerability and isolation. In general, adolescent pregnancy increases the social and economic burdens on a family, affecting its stability and ability to meet basic needs. (See Girl Effect Rwanda, 2020; Umumararungu and Bazubagira, 2023).

Overall, research in Rwanda has provided valuable insights into the socio-cultural, economic, and systemic drivers of adolescent pregnancy, but is predominantly quantitative. Few studies have included control groups for comparison, making it difficult to establish whether factors and effects are specific to adolescent mothers or are equally present among adolescents who are not mothers. As a result, research needs to look more deeply at the psychosocial influences that shape adolescent sexual and reproductive health behaviours, as well as the consequences of pregnancy and early motherhood on adolescent mothers and their families. By adopting a mixed methods approach and case control design, future research can develop a more nuanced understanding, creating the evidence base for interventions and support programmes that can effectively mitigate the incidence and adverse effects of adolescent pregnancy in Rwanda.

2.3 Conceptual framework

The conceptual framework of this study guided the research team's investigation into both the psychosocial determinants of adolescent pregnancy and the consequences of pregnancy and early motherhood on adolescent mothers. Figure 1 depicts the framework.

Figure 1: Conceptual framework of the study



The study's conceptual framework explores the relation between selected psychosocial factors that cause adolescent pregnancy and psycho-social effects of adolescent pregnancy and motherhood. Psychosocial factors are defined as independent variables that influence the occurrence of adolescent pregnancy. They include peer pressure, parenting styles, adolescent sexual and reproductive health literacy, adolescent decision-making abilities, and the incidence and character of sexual behaviour. By examining how these factors intersect and influence adolescents' reproductive decisions, the framework throws light on the underlying determinants of adolescent pregnancy.

In this context, adolescent pregnancy and motherhood are a dependent variable - an outcome influenced by the psychosocial factors mentioned above. As adolescents navigate their social environments and personal circumstances, their susceptibility to peer pressure, the quality of parental guidance, and their level of SRH literacy shape their reproductive choices. Additional factors, such as poor decision-making ability or risky sexual behaviour, increase the risks of early pregnancy.

The psychosocial consequences of adolescent pregnancy are dependent variables that show the impact of early motherhood on adolescents' mental and emotional wellbeing. Consequences include PTSD, depression and anxiety. The experience of adolescent pregnancy can worsen young mothers' existing mental health issues or precipitate new ones. The framework provided a theoretical foundation and organising structure, which guided the design, implementation, and interpretation of the research study.

3. METHODOLOGY

This chapter sets out the study's design, population, data collection methods and sampling procedures. It also describes how data were analysed, how the research report was drafted, and its quality and ethical assurances.

3.1 Study design

The research team adopted a case-control study design. Setia (2016) described such designs as follows: "In a case-control study, participants are selected for the study based on their outcome status. Thus, some participants have the outcome of interest (referred to as cases), whereas others do not have the outcome of interest (referred to as controls). The investigator then assesses the exposure in both these groups. Thus, by design, in a case-control study, the outcome has to occur in some of the participants that have been included in the study" (p.146).

The study used a case-control design to compare adolescent mothers (cases) with adolescent non-mothers (controls) in the same age range. The research team identified a group of adolescents who had experienced pregnancy and compared them with a control group of adolescents who had never been pregnant. By comparing the two groups, the research aimed to assess the psychological determinants and effects of adolescent pregnancy. It was able to identify differences in the psychosocial profile of adolescent mothers and adolescent non-mothers, and specific effects of pregnancy on adolescent mothers that were not experienced by adolescents who had never been pregnant.

3.2 Study population

The primary population studied was adolescent mothers aged between 10 to 19 and their families (resident in Rwanda). The wide age range was based on date from the 2022 GMO and MIGEPROF, which revealed the complex nature of adolescent pregnancy in Rwanda: adolescent mothers in Rwanda included girls from age ten, girls from diverse backgrounds, and girls at various stages of development.

The age range chosen aligned with the demographic profile of adolescent pregnancies in Rwanda, ensuring that the study captured the full spectrum of experiences and challenges faced by adolescent mothers in a variety of age groups. It therefore provided a nuanced picture of factors that contribute to early pregnancy and their impacts on psychosocial wellbeing.

Focusing on adolescent mothers aged 10 to 19 also allowed the research team to identify age-specific patterns and disparities in the determinants and consequences of adolescent pregnancy. Thie age-stratified approach was crucial when it came to tailoring interventions and support services to meet the distinct needs of different groups of adolescent mothers, taking into account their developmental stages, socio-cultural contexts, and specific vulnerabilities.

Overall, the age range of the study population reflected the demographic reality of adolescent pregnancy in Rwanda and enabled the project to examine comprehensively the many issues that influence early motherhood.

3.3 Study approaches

The research relied on two major approaches: the mixed-methods approach and participatory action research (PAR). The mixed-methods approach, integrating both quantitative and qualitative methods, helped the research team to explore the complexities of adolescent pregnancy in Rwanda and obtain a nuanced understanding of the psychological factors that influence the reproductive health decisions of adolescents and the effects of pregnancy on adolescent mothers and their families.

The PAR approach encouraged the research team to collaborate very closely with the participants and other stakeholders. Through PAR, community members were able to actively contribute insights and perspectives, ensuring that the research process was inclusive and holistic. Adopted a collaborative approach deepened understanding of the psychological factors that influence adolescents' reproductive health decisions and the effects of pregnancy on adolescent mothers and their families.

The team also engaged actively with key stakeholders, including government institutions. Key bodies included the Ministry of Gender and Family Promotion (MIGEPROF), the Ministry of National Unity and Civic Engagement (MINUBUMWE), and the Rwanda Biomedical Center (RBC). These institutions contributed valuable insights and ensured that the team's research findings aligned with national priorities related to adolescent reproductive health and psychosocial support. Additionally, the involvement of civil society organisations (CSOs) specialising in mental health, gender equality, and youth empowerment enhanced community engagement and advocacy efforts, ensuring that interventions were responsive to the needs of adolescent mothers and other vulnerable populations.

PAR ensured that stakeholders did much more than help to collect data. They participated actively throughout the research process: they contributed to the design of research instruments, identified research sites, facilitated community involvement, and collaborated in the analysis and interpretation of data. By becoming co-researchers, stakeholders developed a sense of ownership and commitment to the project's outcomes, which encouraged a culture of collaboration and mutual accountability.

Overall, the engagement of relevant government institutions and CSOs via the PAR process strengthened the study's credibility, relevance, and potential impact. By integrating local knowledge and priorities in the research process, PAR promoted evidence-based decision-making and facilitated the development of more effective policies and programmes to support adolescent mothers and address adolescent pregnancy.

3.4 Data collection methods

In line with the study's objectives and the approaches outlined above, the research team employed four primary data collection methods: desk review, structured questionnaire surveys, focus group discussions (FGDs), and key informant interviews (KIIs).

Desk review. A desk review surveyed the available literature, including books, research reports, institutional reports, journal articles, and media articles on the scale, causes, and effects of adolescent pregnancy in Rwanda and internationally. This work was also helpful when it came to drafting the project's findings.

Survey questionnaire. To collect quantitative data, the research team designed and administered a structured questionnaire for adolescent mothers (the case group) that assessed the degree to which adolescent pregnancy is associated with specific psychosocial vulnerabilities or challenges that female adolescents face.

Adolescent non-mothers (the control group) answered a similar questionnaire. The questionnaire was tablet-based and administered by skilled and trained female enumerators under the close supervision of field team leaders.

Focus group discussions (FGDs). The team organised a number of FGDs that brought together a variety of participants, including adolescent mothers, parents/guardians of adolescent mothers, and other local opinion leaders. Each FGD convened about 10 participants. They were moderated by Interpeace investigators, who are skilled in creating a supportive and non-judgmental environment conducive to open dialogue. A semi-structured interview guide gave direction to the discussion. This qualitative methodology was used to explore participants' perceptions, attitudes, and shared experiences as well as associated psychosocial factors that influence the incidence of adolescent pregnancy. To make the FGDs accessible and comfortable for participants, they took place in community settings, such as local schools, sector offices, or health centres. An effort was made to ensure that FGDs with parents and opinion leaders were gender balanced and represented a variety of socio-economic backgrounds.

Key informant interviews (KIIs). The research team organised interviews with community leaders, health professionals, and experts in the field. KIIs provided nuanced insights into the perspectives of those with expertise on the subject. They enabled the team to obtain a deeper understanding of psychological factors that influence the incidence of adolescent pregnancy and its effects.

The project's decision to adopt a PAR approach ensured that the research process was inclusive and holistic. It enabled the community to contribute actively to all stages of the research, and generated insights that more traditional research methods might have missed.

Overall, the use of both quantitative and qualitative methods, enhanced by PAR, enabled the team to obtain a comprehensive and nuanced understanding of the factors that influence adolescent pregnancy in modern Rwanda.

3.5 Sample size and sampling techniques

Quantitative component

Determining the sample size

The sample size was determined on the basis of three calculations: (1) the size of the sample of adolescent mothers (the case group); (2) the size of the sample of adolescent non-mothers (the control group); and (3) the number of districts included in the study. The sample size for adolescent mothers was calculated using the Raosoft Sample Size Calculator, applying the following parameters: the size of the study population (24,472 adolescent pregnancies recorded between January and December 2022); the margin of error (5%); the confidence level (98%); and the response distribution (50%). This calculation generated a sample size of 530 (adolescent mothers).

To mitigate the effect of non-responses, the project assumed a 10% non-response rate, which corrected the sample size to 583 [n = 530 + (530 * 10/100) = 530 + 53 = 583]. This figure was rounded up to 600 (adolescent mothers).

To enable comparison, the sample size for the control group (adolescent non-mothers) was also set at 600. Altogether, the total sample size for the quantitative component was therefore 1,200 individuals. In the end, the study recruited 1,174 individuals (97.83% of the target sample). Of these, 587 were adolescent mothers (97.83% of the target) and 587 were adolescent non-mothers (also 97.83% of the target).

The shortfall was due to difficulty in finding eligible respondents. Specifically, 2.17% of the expected sample size could not be reached because some adolescent mothers had relocated to other areas; while several adolescent non-mothers, required for matching purposes, were unavailable because they were attending school. (For the distribution of respondents per district, please see Table 1.) Despite these challenges, the research team was able to ensure that the samples were proportional and demographically balanced, as originally intended, ensuring the validity and reliability of the study's findings.

With respect to the number of districts, given that the study targeted a hard-to-reach population (adolescent mothers) which was unevenly distributed across provinces and districts, the project focused on five districts. A non-probabilistic (purposive) method and multi-stage sampling techniques were used to select these. Four of the districts had the highest number of adolescent mothers in their province (Nyagatare, Musanze, Rubavu, Gisagara); the fifth (Gasabo) was in Kigali, the capital. The Gender Monitoring Office (GMO) and MIGEPROF provided the number of adolescent mothers per district. Officials from each district were expected to provide their distribution in sectors and cells (if any). The number of sectors and cells selected was determined on the basis of the distribution, taking into account the highest prevalence of cases.

The control group was selected using a method known as propensity matching, to ensure comparability between adolescent mothers and adolescent non-mothers. This approach involved pairing each adolescent mother with a non-mother from the same village and cell, matching them based on age, geographical location, and their household's Ubudehe category.[4]

This meticulous matching was done without replacement, ensuring that each pair shared a similar demographic profile. In this way, the study minimised the risk of confounding variables and enhanced the reliability of its findings. The matching process included a rigorous verification step to confirm the compatibility of each pair; any discrepancies in demographic attributes were carefully resolved.

Local leaders helped to verify the demographic information on each participant, using their deep knowledge of the community to ensure that pairings were accurate and aligned with the study's criteria. Their involvement also helped to build trust and rapport with the community, increasing households' willingness to participate in the study.

The research team conducted field visits in the sampled districts before starting data collection. These visits made it possible to establish a rapport with local communities and secure the buy-in of key stakeholders. The team also explained the study's purpose and addressed any concerns, making clear that the privacy and confidentiality of participants would be respected throughout the process.

Overall, this approach not only strengthened the validity of the study but ensured that any observed differences between the case group and the control group could be attributed directly to the effects of adolescent pregnancy. This permitted the team to draw precise conclusions about the psychosocial impacts of adolescent pregnancy.

4 The Ubudehe is a socio-economic classification system in Rwanda that assesses the socioeconomic status of households.

Qualitative component

Determining the sample size. For the qualitative phase of the study, the research team convened 20 FGDs: four were conducted in each of the five selected districts. These discussions specifically targeted adolescent mothers, their parents or guardians, and local opinion leaders. Several criteria were used to select participants, including their willingness to participate, the quality of their experience, and their socio-economic and demographic background (education level, type of residence, income).

In each district:

- Two FGDs were held with adolescent mothers,
- One FGD was held with the parents or guardians of adolescent mothers.
- One FGD was held with local opinion leaders.

About ten participants attended each FGD. This approach ensured that every group could include a variety of perspectives and experiences in different geographical areas, thereby enriching the data.

Key informant interviews (KIIs) were also an integral part of the qualitative phase. They targeted national and local decision-makers, researchers, and practitioners with expertise in mental health, societal healing, and adolescent sexual and reproductive health. At national level, KIIs mainly targeted officials from MENEDUC, the Rwanda Biomedical Centre (RBC), and non-governmental organisations such as Haguruka, the Health Development Initiative (HDI), and Empower Rwanda. At local government level, KIIs involved the Vice Mayor of Social Affairs, district mental health directors, directors of district hospitals, Isange One Stop Centre coordinators, gender officers, and female head teachers. These interviews provided valuable insights and perspectives from individuals who are directly involved in addressing adolescent pregnancy and associated psychosocial factors.

To enable the team to obtain a comprehensive understanding of the subject matter, the study adopted a purposive sampling technique to select key informants. It deliberately selected participants based on specific criteria that prioritised diversity with respect to professional background, expertise, and experience of adolescent reproductive health and mental wellbeing.

The KIIs enriched the qualitative data collected, and added nuanced perspectives that subsequently informed the study's recommendations.

3.6 Data collection

Before the research team started to collect data, it requested the Rwanda National Ethics Committee (RNEC) to grant ethical clearance. It also recruited and trained a team of skilled enumerators. The training covered the study's objectives and methodology, the questionnaire's structure, content and administration, and the enumerators' code of conduct. As part of the training, the questionnaire was tested to check that its questions were clear and coherent.

Data collection was sequenced. In the first place, the enumerators used tablet-based survey questionnaires, designed in Kobo Toolbox software, to collect quantitative information on the demographic characteristics and psychosocial profile of adolescent mothers and their families, as well as their knowledge of reproductive health. This information subsequently informed the final draft of the interview guides for FGDs and KIIs. The

qualitative meetings examined the participants' experiences and perceptions of adolescent pregnancy, incorporating insights gleaned from the quantitative analysis. The collection of qualitative data was facilitated by Interpeace's research team. Data were first recorded and then transcribed for analysis.

This sequential approach enabled the research team to triangulate data from multiple sources. This enriched understanding of the issue, and ultimately informed the study's recommendations.

3.7 Data analysis

The study hired a statistician to lead analysis of the quantitative data. As noted, quantitative information was collected using a tablet-based questionnaire designed in Kobo Toolbox software. The information was uploaded daily on to the server, then imported into Excel for cleaning, and finally imported into the Statistical Package for Social Sciences (SPSS) for analysis. The research team employed univariate analysis to examine basic demographic information and to identify the psychosocial profiles of adolescent mothers before and after pregnancy, as well as the profile of adolescent non-mothers. Logistic regression models were used to identify factors that contribute to the incidence of adolescent pregnancy and its psychosocial effects on adolescent mothers, and compare the psychological profiles of adolescent mothers and non-mothers in order to pin down factors that may be specifically associated with adolescent pregnancy.

Qualitative data, including FDGs, KIIs and field notes, were transcribed and analysed thematically, using comprehensive data review, code generation through open coding, theme identification, and theme refinement to capture salient patterns and meanings. The final write-up integrated primary data with secondary data from existing literature, taking care to respect ethical norms of confidentiality and anonymity. This integrated approach ensured that the team obtained a holistic understanding of adolescent pregnancy, combining quantitative rigor with qualitative depth.

After analysis and reflection, the team formulated its research findings, and drafted actionable recommendations to address the challenges of adolescent pregnancy and establish effective psychosocial support models that will improve the wellbeing of young mothers in Rwanda.

3.8 Drafting the report

The final report drew on the integrated analysis of quantitative and qualitative findings. It described the factors the team had identified, and their interconnections and implications. It also reflected the participatory nature of the research, by ensuring that the voices of affected adolescents and other stakeholders were accurately represented. Recommendations for interventions and policies to address the issue were also based on the research findings. They aim to contribute to positive changes in the reproductive health outcomes of Rwandan female adolescents.

3.9 Ethical considerations

Interpeace believes that ethical norms of research must be respected to ensure the wellbeing, dignity, and rights of participants. By adhering to ethical guidelines and practices, we foster trust between our researchers and participants, uphold principles of justice and fairness, and mitigate potential harm or exploitation. This promotes the credibility and reliability of our research findings. The research team therefore prioritised ethical

conduct at every stage. There were also particular reasons to implement this study ethically. First, the research discussed psychological matters that were likely to affect participants emotionally. Second, the study involved adolescents, who by definition are vulnerable because they are minors. Third, the study focused on adolescent mothers, a state associated with physical and mental health problems, but also social stigma. To address these concerns, the team took the following steps:

Application for ethical clearance. Before collecting data, Interpeace shared the research protocol with the Rwanda National Ethical Committee (RNEC) which is responsible in Rwanda for granting ethical clearance. The RNEC's review process enabled the project to test its research protocol and minimise the danger of causing harm to participants.

Informed consent form (parents/guardians). Given their age, adolescent mothers were not in a position to consent to participate in the research project. The project requested parents and guardians to do this on their behalf.

Assent form (adolescent mothers and adolescent non-mothers). In addition to the consent form, the project asked all participants to sign an assent form.

Contingency measures

Recognising that unforeseen challenges or emergencies were likely to arise during the study, we devised contingency measures to ensure the safety and wellbeing of participants as well as the ethical integrity of our research. These measures included the following:

- In collaboration with RBC, we compiled a list of emergency contact numbers, including the numbers of local health facilities for potential referrals.
- We established clear channels of communication between research team members to facilitate coordination during emergencies.
- Our programme senior psychotherapist and our gender and inclusion adviser served as primary points of contact. They were responsible for initiating the emergency response plan, and communicating with emergency services. Interpeace was responsible for covering any related costs that were not initially covered by the community-based health insurance programme (Mutuelle de Sante) or by other relevant insurances to which participants might be affiliated.
- Our enumerators' team largely comprised women with a background in psychological education.
- Our research team was trained in severe distress emergency, basic first aid, and emergency response procedures.
- During the training of enumerators, Interpeace's programme psychotherapists facilitated a session that discussed the emotions that participants might experience during interviews, and provided guidance on appropriate support.
- We established procedures for documenting details of any emergency response (for example, actions taken by research team members, communication with emergency services and other relevant parties, and injuries or incidents).

- ➔ Interpeace's research team and psychologists regularly monitored and supervised the research process to make sure that any issues were addressed promptly, and to adapt our procedures if required.

Overall, we were committed to upholding the highest standards of ethical conduct and prioritising the welfare of participants throughout the research process.

3.10 Quality assurance

To ensure the quality of data as well as stakeholder engagement, the study's methodology, data collection tools, preliminary findings, and draft report were thoroughly reviewed by key stakeholders, including representatives of MIGEPROF, MINUBUMWE, the Rwanda Biomedical Centre (RBC), and civil society organisations specialising in mental health, gender equality, and youth empowerment. Their input ensured that the project remained aligned with national priorities and community needs.

The research protocol was approved by the Rwanda National Ethics Committee (RNEC). Its procedure enhanced the study's ethical and methodological rigour, and minimised risks of harm to the participants. Training sessions standardised data collection procedures and incorporated ethical guidelines, supported by a detailed manual.

Through regular supervision and periodic stakeholder meetings, the project team addressed challenges, reviewed progress, and maintained consistency. The active participation of stakeholders fostered a sense of ownership and accountability, significantly enhancing the reliability, relevance, and credibility of the research outcomes.

Validity and reliability check

During the collection of quantitative data, the project tested the validity and reliability of its survey instruments by pre-testing them with a small sample of participants. This pilot helped to identify ambiguities or other concerns, and made it possible to perfect the instruments before full-scale implementation. The use of multiple data sources, methods, and researchers (triangulation) enhanced the credibility and dependability of the study's findings. These measures collectively ensured that the study's outcomes were trustworthy and robust.

4. FINDINGS

This chapter presents the findings of the study, directly addressing the study's objectives. It analyses psychosocial factors that contribute to adolescent pregnancy and its subsequent impact on the mental health and wellbeing of adolescent mothers and their families. Integrating quantitative with qualitative data, the chapter highlights key patterns and differences in the profiles of adolescent mothers and adolescent non-mothers, and describes the challenges faced by adolescent mothers. The findings provide evidence upon which strategies to enhance psychosocial support to adolescent mothers in Rwanda, and improve their health outcomes, can be based.

4.1 Demographics

This section provides a demographic profile of the participants. It categorises them by their status as mothers or non-mothers, and describes their distribution in terms of district, age, and level of education. The data provide a comprehensive overview of the population studied, and highlight trends and differences that may influence both the results of the study and the development of targeted interventions.

Table 1: Participants' demographic profile

	Mothers	Non-mothers
District		
Gasabo	98 (16.70)	98 (16.70)
Gisagara	127 (21.64)	127 (21.64)
Musanze	121 (20.61)	121 (20.61)
Nyagatare	120 (20.44)	120 (20.44)
Rubavu	121 (20.61)	121 (20.61)
Age		
10-13 years old	0 (0)	0 (0)
14 years old	2 (0.34)	2 (0.34)
15 years old	6 (1.02)	6 (1.02)
16 years old	30 (5.11)	30 (5.11)
17 years old	147 (25.04)	147 (25.04)
18 years old	191 (32.54)	191 (32.54)
19 years old	211 (35.95)	211 (35.95)
Level of education		
No formal education	143 (24.36)	75 (12.78)
Incomplete primary	134 (22.83)	74 (12.61)
Ordinary level	45 (7.67)	71 (12.1)
Primary school	259 (44.12)	351 (59.8)
Secondary school	1 (0.17)	11 (1.87)
University	1 (0.17)	
Vocational/technical training	4 (0.68)	5 (0.85)
Total	587 (100)	587 (100)

Table 1 shows the demographic distribution of participants based on their districts, age and level of education. The geographical distribution of respondents shows a generally consistent spread across the five districts involved in the study, reflecting the project's wish to capture diverse regional perspectives. However, Gasabo (a district in the city of Kigali) showed a slightly lower participation rate. In both the case and control groups, Gasabo reported 98 respondents (16.7% of the total in each group). This was slightly lower than Gisagara,

Musanze, Nyagatare, and Rubavu, which each reported approximately 20.6% of all respondents. With 120 respondents, Nyagatare reported 20.44% of the total.

The discrepancy in Gasabo's numbers can be attributed to the high mobility of its adolescent mother population. It was observed during field visits that, by the time enumerators reached the area, several of the identified participants had relocated. This mobility is likely to be linked to socio-economic factors associated with urban settings like Kigali, where housing and economic opportunities prompt frequent moves. This dynamic made it difficult to maintain a stable sample size and could influence the reliability of data from this district. This suggests that future studies should adopt strategies to account for or manage such variances.

With respect to the age profile, most participants were older adolescents. Those aged 18 and 19 years old were the majority. These two year groups together accounted for approximately 68% of participants, indicating that a higher proportion of older teenagers report their pregnancies. The number of younger adolescents was notably lower; only a handful of participants were aged 14 and 15 years. This age distribution may reflect a lower incidence of pregnancy among younger adolescents, poorer access to these age groups, or lower reporting of pregnancy by these age groups.

The analysis of educational attainment shows differences between adolescent mothers and adolescent non-mothers. A significant proportion of adolescent mothers had limited education: 24.36% had no formal education and 44.12% had only completed primary school. This suggests a correlation between lower educational levels and likelihood of adolescent pregnancy. In contrast, adolescent non-mothers generally had higher educational attainments: the majority had completed or gone beyond primary education. This highlights the protective role that continued education may play in preventing adolescent pregnancy. The low number of mothers in secondary and higher education also confirms that pregnancy may critically disrupt education.

The demographic profile provides crucial insights into the socio-economic and educational context in which adolescent pregnancy occurs in Rwanda. It underscores the need to promote education programmes and interventions that prevent adolescent pregnancies but also support adolescent mothers to continue their education, thereby breaking a cycle of socio-economic disadvantage and promoting better health and economic outcomes for young women and their families.

4.2 Sexual and reproductive health education and behaviour

This section of the report delves into the sexual and reproductive health (SRH) education that adolescent mothers and non-mothers receive. It examines their access to SRH information before significant life events and analyses adolescents' primary sources of sexual education, such as family, schools, and media. The data reveal differences in access to SRH education between adolescent mothers and non-mothers, underscoring its impact on their sexual health decisions and outcomes. The analysis explores the sources and adequacy of SRH knowledge but also broader themes of adolescent behaviour, including contraceptive use, and the social influences on young women's lives

Table 2: Access of female adolescents to information on sexual and reproductive health (SRH)

Did you receive SRH education or information?

	Adolescent mothers[5]	Adolescent non-mothers
No	376 (64.05)	140 (23.9)
Yes	211 (35.95)	447 (76.1)

The data on SRH education highlight a substantial discrepancy that has implications for public health interventions to reduce adolescent pregnancy. According to the survey, only 35.95% of adolescent mothers received SRH education prior to the sexual activity that resulted in their pregnancy. This indicates a critical gap in preventive education that could potentially arm young women with knowledge and resources that would enable them to avoid unintended pregnancy.

Conversely, 76.1% of adolescent non-mothers reported that they had access to SRH education, suggesting that SRH education reached this group more successfully. The significant difference in educational exposure between the two groups underscores the potential impact of effective SRH education in preventing adolescent pregnancy. It highlights the need for targeted educational programmes that reach at-risk populations before they become sexually active.

The lower rate of SRH education among adolescent mothers suggest that systemic barriers (socio-economic factors, cultural stigmas about young women's sexuality, logistical challenges, or lack of educational programmes) may prevent them from accessing these crucial resources. The high mobility of adolescent mothers in urban districts such as Gasabo further complicates efforts to deliver consistent and effective SRH messages.

These findings suggest that enhancing the reach and effectiveness of SRH education could significantly reduce the incidence of adolescent pregnancy by giving young women information and tools that enable them to make informed and conscious decisions about their sexual health before, and when, they engage in sexual activity. Table 3 assesses the major sources of SRH information that participants reported.

Table 3: Sources of information on sexual and reproductive health

What were your main sources of information on sexual and reproductive health?

Source	Adolescent mothers	Adolescent non-mothers
Family	48 (22.86)	128 (28.64)
School	140 (66.67)	350 (78.3)
Media	25 (11.9)	38 (8.5)
Peers	35 (16.67)	66 (14.77)
Local officials	6 (2.86)	18 (4.03)
Church	0	8 (1.79)
CSOs	29 (13.81)	55 (12.3)
Health facilities	9 (4.29)	41 (9.17)
Community health workers	7 (3.33)	7 (1.57)
Friends	22 (10.48)	27 (6.04)
Other	5 (2.38)	21(4.7)

5 Adolescent mothers were asked whether they had access to SRH information before the sexual intercourse that resulted in their (first) pregnancy.

The analysis of sources of SRH information reveals significant differences between adolescent mothers and adolescent non-mothers, which are influenced by their educational backgrounds and social environments. Adolescent non-mothers, who typically have higher educational levels, reported that they had more access to SRH information from schools (78.3%) than adolescent mothers (66.67%). This indicates that higher education correlates with better access to information but also contact with the institutional support systems that are available in educational settings, highlighting the critical role of schools in disseminating SRH knowledge.

Health facilities were also used more often by adolescent non-mothers (9.17%) than adolescent mothers (4.29%), suggesting that non-mothers might have better access to or put more trust in formal healthcare services, facilitated by their higher educational level. This underscores the important contribution of education to health literacy; it helps individuals to navigate and use healthcare services.

Family emerged as a significant source of SRH information, again more for adolescent non-mothers (28.64%) than adolescent mothers (22.86%). The difference may suggest that the families of adolescent non-mothers are more ready to discuss SRH, perhaps to preserve their daughters' educational and socioeconomic prospects, perhaps also out of a desire to influence their daughter's sexual and health behaviour.

Interestingly, the church, which often plays a vital role in community education, particularly in conservative settings, did not provide SRH information to mothers; it was a source for just 1.79% of adolescent non-mothers. This might indicate a gap in the outreach strategies of religious institutions. Were they to provide more support and advice to adolescent women, adolescent mothers might be perceived differently and might be less subject to the stigma associated with early pregnancy.

Peers were a relatively common source of information for both adolescent non-mothers (14.77%) and adolescent mothers (16.67%). This highlights that peer influence remains a significant factor for all adolescents, regardless of educational status. However, the variable quality of the information that peers provide is a further reminder that all adolescents need access to accurate and reliable SRH information through formal channels.

These findings underscore the need for strategies that extend SRH education beyond traditional school settings to reach adolescents not in the education system, such as adolescent mothers. Expanding the scope and reach of SRH education can reduce disparities in knowledge, improve adolescent health outcomes, and enhance the overall effectiveness of health education programmes.

Table 4: Age at first sexual intercourse

Age	Adolescent mothers	Adolescent non-mothers
Under 15 years old	123 (20.95)	37 (35.58)
15-17 years old	417 (71.04)	35 (33.65)
18-19 years old	47 (8.01)	32 (30.77)
Total	587 (100.00)	104 (100.00)

When analysing Table 4, it is important to understand the differences between the experience of adolescent mothers and adolescent non-mothers, particularly in the context of SRH education and its impact on adolescent pregnancy. The data reveal that a significant proportion of adolescent mothers (71.04%) became sexually active between the ages of 15 and 17. This suggests that sexual activity often begins in mid-adolescence, which correlates with the risk period for early pregnancy, particularly when adequate sexual health education and contraceptive resources are lacking.

For adolescent non-mothers, the picture is markedly different. Out of 587 adolescent non-mothers surveyed, only 104 (17.72%) reported having had sexual intercourse at all. This indicates a higher propensity among

non-mothers to delay sexual initiation, which could be linked to better access to education and reproductive health resources, or to socio-cultural influences that discourage early sexual activity.

Of the non-mothers who did engage in sexual activity, 35.58% reported that they became active before the age of 15, a higher proportion than adolescent mothers (20.95%). This unexpected finding could suggest that adolescent non-mothers successfully prevent early pregnancy by using contraception or applying their knowledge of SRH.

30.77% of sexually active adolescent non-mothers became active between the ages of 18 and 19, highlighting a trend towards later sexual initiation. This group's delayed start could reflect a more mature approach to sexual engagement, possibly underpinned by higher levels of education and better access to SRH information.

These insights underscore the importance of targeted SRH health education that addresses the needs of adolescents at various stages of their development. Providing young people with the tools and knowledge they need to make informed decisions about their sexual health and behaviour is a crucial component of efforts to reduce the incidence of adolescent pregnancy and support young women's overall wellbeing.

Table 5: Use of contraceptives

Did you think of using contraceptives when you had sexual intercourse?

	Adolescent mothers[6]		Adolescent non-mothers	
No	541	(92.16)	49	(47.12)
Yes	46	(7.84)	55	(52.88)
Total	587	(100.00)	104	(100.00)

The data reveal that 92.16% of adolescent mothers did not consider using contraceptives during sexual intercourse, a starkly higher proportion than adolescent non-mothers (47.12%). This highlights a significant gap in contraceptive awareness or access among adolescent mothers. The lack of contraceptive use among this group may reflect limited sexual and reproductive health (SRH) education, cultural stigma with respect to contraceptives, or limited access to youth-friendly healthcare services. The gap may also be due to unequal power dynamics in relationships, that prevent some adolescent mothers from being able to negotiate contraceptive use.

In contrast, 52.88% of adolescent non-mothers reported thinking of contraceptives when they had sexual intercourse. This suggests that non-mothers may have had better access to SRH education or resources, possibly through schools, community programmes, or family discussions. The higher awareness among non-mothers may also indicate a shift in societal attitudes and norms. This underlines the importance of comprehensive SRH programmes for all adolescents.

The contrast between the two groups underscores the urgent need for effective preventive interventions. Adolescent mothers who did not consider contraceptives may have been unaware of the risks or lacked access to services before becoming pregnant. On the other hand, the higher percentage of non-mothers thinking about contraceptives points to the potential success of prevention programmes, suggesting that timely SRH education and access to contraceptives can significantly reduce adolescent pregnancy.

The data may also reflect structural and societal barriers to contraceptive use, such as stigma, misinformation, or gender inequality. Adolescents often face societal judgment for seeking contraceptives, while healthcare

6 Adolescent mothers were asked whether or not they had considered using contraceptives when they had the sexual intercourse that resulted in their (most recent) pregnancy.

providers may not offer youth-friendly services. Moreover, the economic hardships and relational pressures some adolescents face might prevent them from prioritising contraceptive use, highlighting the need for interventions tailored to their realities.

The findings emphasise the need for targeted education and service delivery. For non-mothers, continuing and expanding SRH education in schools and communities can reinforce positive behaviours. For mothers, interventions must focus on preventing repeat pregnancies through education, counselling, and easy access to contraceptives. Tailored programmes for out-of-school adolescents are also critical, as they may have less access to formal education on SRH topics.

Actual reasons for not using contraceptives are discussed in Table 6.

Table 6: Reasons for not using contraceptives

If you answered No, why didn't you use a contraceptive method?

Reason	Adolescent mothers[7]	Adolescent non-mothers[8]
Fear of side effects	10 (1.85)	
Inaccurate or incomplete knowledge of contraception	198 (36.60)	20 (40.82)
Religious belief	2 (0.37)	
My partner refused it	31 (5.73)	1 (2.04)
It was a forced sexual intercourse	59 (10.91)	4 (8.16)
Contraception was not affordable	4 (0.74)	
Contraception was not available	13 (2.4)	2 (4.08)
Perceived low risk of pregnancy	134 (24.77)	
Desire for pregnancy	3 (0.55)	1 (2.04)
It was unplanned and happened without proper preparation	159 (29.39)	15 (30.61)
Other	33 (6.10)	6 (12.24)

The reasons that adolescent mothers and non-mothers gave for not using contraceptives during their first sexual encounters provide a revealing insight into the barriers to effective contraceptive use in Rwanda. The reasons given by adolescent mothers reflect a mix of lack of knowledge, societal pressure and relational dynamics. Notably, a significant proportion of adolescent mothers (36.6%) said that they lacked accurate or sufficient knowledge of contraception, highlighting a critical gap in SRH education. This issue was also mentioned by many adolescent non-mothers, 40.82% of whom acknowledged similar gaps in knowledge, underscoring the need to improve educational outreach in both groups.

A considerable number of adolescent mothers (29.39%) reported that the sexual intercourse that led to pregnancy was unplanned and occurred without proper preparation, suggesting a reactive rather than proactive approach to contraceptive use. This is mirrored by the experience of adolescent non-mothers, 30.61% of whom reported spontaneous sexual encounters.

An alarmingly high proportion of adolescent mothers (10.91%) reported that sexual intercourse had been

7 N=541.
8 N=49.

forced. This underlines the harsh reality of sexual violence that some young women face, which drastically reduces their ability to negotiate contraceptive use. Many, though fewer, adolescent non-mothers (8.16%) reported the same experience. It is crucial to note that, under Rwandan law, any sexual intercourse with a minor is legally considered to be defilement, because minors do not have the legal capacity to consent. During the FGDs, some adolescent mothers described forced sexual encounters that had resulted in pregnancy. These reports underlined the severe consequences of sexual violence.

> *"I was on my way to fetch water, though I had been in a relationship with a boy who was a friend of mine. However, we eventually broke up, and he betrayed me, setting me up with his other friends. One of his friends, along with two other boys, ambushed me on the path while I was carrying water jugs. It was around 5:30 p.m., just as evening was approaching. One of them came up from behind and struck me with a jerry can. I screamed for help, and they all ran except for one, who hid nearby, watching to see if anyone would come. When he realised no one was coming, he returned. He tore the dress I was wearing, and despite my struggle, the assault happened.*
>
> *At the time, I didn't know that I had become pregnant. I kept it hidden and didn't say anything. But a month later, I realised I was expecting, so I decided to tell my family. When I did, they rejected me, saying that, if it were true, I should have told them sooner. After they threw me out, I spent the next seven months living outside, sometimes sleeping at a friend's place. (An adolescent mother, 17 years old, FGD, Rubavu District).*

The influence of partners is another notable factor. Some adolescent mothers (5.73%) indicated that their partners refused to use contraceptives; less frequently, the partners of adolescent non-mothers (2.04%) also did so.

Misconceptions about, or underestimations, of pregnancy risk were significant. 24.77% of adolescent mothers believed they were unlikely to become pregnant at the time of intercourse. This indicates that they did not grasp the degree to which sexual activity is likely to result in conception, a misunderstanding that will clearly tend to increase rates of unintended pregnancy.

These findings show that many factors impede contraceptive use among adolescents. They include lack of SRH education, partner influence, economic factors, and access issues. A combination of comprehensive sexual education, community outreach programmes, and youth-friendly health services would enhance adolescents' knowledge and use of contraceptives, which in turn would reduce the number of unintended adolescent pregnancies.

Table 7: Contraceptive methods used by adolescents

If you answered Yes, which methods did you consider using?

Method	Adolescent mothers	Adolescent non-mothers
Birth control pills	5 (10.87)	6 (10.91)
Condoms	30 (65.22)	48 (87.27)
Injectable contraceptives	1 (2.17)	1 (1.82)
Morning-after pill	1 (2.17)	
Natural method	4 (8.70)	
Other (specify)	5 (10.87)	
Total	46 (100.00)	55 (100.00)

The answers to this question were revealing. Condoms were the contraceptive that both groups considered most frequently, though adolescent non-mothers (87.27%) were more likely to do so than adolescent mothers (65.22%). This suggests that adolescent non-mothers may have better access to condoms, or are more aware of their prophylactic value – which may be due, in turn, to the efforts of many health education campaigns to promote condoms as the primary safe sex method.

Birth control pills were contemplated by a small fraction of both groups, in nearly equal proportion (10.87% of adolescent mothers and 10.91% of adolescent non-mothers). These figures may be attributed to concerns about access, cost, or side effects, all common reasons for not using contraceptive pills in settings that have limited reproductive health resources.

8.70% of adolescent mothers considered using natural methods, which may suggest a preference for, or reliance on, traditional techniques of contraception. This choice may be due to cultural influences or to lack of information about more effective modern contraceptives.

Interestingly, a small but significant proportion of adolescent mothers (10.87%) considered other unspecified methods. This answer may indicate that the women are open to alternative forms of contraception or perhaps that they do not understand what contraceptive methods are effective.

These findings underscore the need for comprehensive SRH education that promotes awareness of all available contraceptive options and removes barriers to accessing them. Enhancing adolescent awareness of a wider range of contraceptives, and making such contraceptives available, could assist adolescents to make more informed decisions and reduce the incidence of unintended pregnancy.

Overall, this analysis of SRH education and sexual behaviour sheds light on the differences of behaviour between adolescent mothers and adolescent non-mothers in Rwanda. Lack of access to SRH information is a critical gap. Compared to adolescent non-mothers, adolescent mothers were much less aware of SRH and SRH services: there is an opportunity here for SRH education that could lower the incidence of adolescent pregnancy. Further, the feedback from participants on their primary sources of SRH information showed that many factors (including education, family involvement, and community resources) influence the decisions and behaviour of young women with respect to sexual health and contraceptive use.

These results prompted the team to recommend enhanced strategies that will broaden the reach and effectiveness of SRH education by making it more accessible to at-risk youth populations, especially adolescent mothers, many of whom lack access to and awareness of contraception and SRH. Interventions should be community-specific and culturally appropriate; in particular, they should aim to inform adolescent women about sexuality and their sexual health and equip them to make informed decisions. Such an approach can significantly reduce rates of adolescent pregnancy, improve the broader health and wellbeing of young women in Rwanda, and support their transition into adulthood.

4.3 Insights into adolescent pregnancy

The study generated information about the age at which young women became sexually active, the types of partnership they entered into, and the marital status of partners at the time of conception. This information helps to unravel the interplay between the personal relationships of adolescent women and broader societal norms that influence adolescent pregnancy outcomes. It sheds light on the dynamics of their relationships, which include consensual partnerships but also more problematic or abusive relationships that involve power imbalances or legal violations, such as defilement or rape. These insights should inform interventions to

address the specific needs of adolescent mothers, whether these enhance their legal protection or promote healthy forms of relationship.

Age of sexual partner

Table 8: Age of the sexual partner (baby's father)

How old was your sexual partner when you first had sexual intercourse?	Number	%
Much older than me (6 years or more)	167	28.45
Slightly older than me (5 years or less)	355	60.48
Same age as me	54	9.20
Don't know	11	1.87
Total	587	100.00

The information that adolescent mothers provided about the partners with whom they first engaged in sexual intercourse reveals a lot about the character of these relationships. Most partners were clearly older, and were therefore likely to have power and influence in the relationship.

60.48% of the participants who responded (355 young women) indicated that their partners were up to five years older. This suggests a social pattern, in which younger women are involved with slightly older men, that perhaps reflects gender norms and expectations in the society. Given the youth of the women, the age difference could imply a maturity gap, which in turn might affect the nature of the partners' interactions and the equality of their decision-making, particularly concerning sexual and reproductive health.

A significant proportion of the participants (28.45%, 167 young women) reported that their sexual partners were more than six years older. This age gap is likely to increase the older partner's authority, potentially limiting the younger partner's autonomy in decision-making and deepening their vulnerability. Relationships with such a marked age difference can put young women at a disadvantage: they are likely to have less control over contraceptive use or the timing of sexual initiation, which both directly affect the likelihood of adolescent pregnancy.

Only 9.20% of the participants (54 young women) indicated that their partners were about the same age. Adolescent girls in this group are likely to experience more equitable relationships than those with older partners. Communication between the partners may be better and decisions on sexual health and sexual activity are more likely to be shared.

Interestingly, 1.87% of the participants (11 young women) did not know the age of their partners. This may imply that these relationships were casual or transient, or that the women were reluctant to disclose this information because of social stigma or personal discomfort. In some cases of rape, as well, the perpetrator may be unknown to the woman or may be unidentified.

Overall, the data show that the sexual partners of most adolescent mothers are older. This can mean that the male partner exercises unequal power in the relationship, with impacts on the sexual health outcomes for the younger female partner. This pattern again underlines the need for targeted interventions that educate and empower young women, enabling them to make informed decisions about their relationships and sexual health. Community and societal interventions may also be necessary to shift norms that support inequitable age-disparate relationships, to reduce their prevalence and the associated risks.

Relationship with the sexual partner

Table 9: Type of relationship with the sexual partner at the time of conception

Relationship type	Number	%
Boyfriend/girlfriend	297	50.60
Casual relationship	160	27.26
Defilement	39	6.64
Family member	5	0.85
My boss	13	2.21
One-time encounter	22	3.75
Simple neighbour	42	7.16
Other (please specify)	9	1.53
Total	587	100.00

The types of relationship that adolescent mothers have with their sexual partners at the time of conception provide insights into the social and relational contexts in which pregnancies occur. Half of the adolescent mothers who participated (50.60%, 297 young women) said that they were in a boyfriend/girlfriend relationship when they conceived. More committed and longer term relationships of this sort imply a greater degree of emotional connection and stability, potentially influencing decisions about contraception and the timing of pregnancy.

A quarter of the adolescent mothers (27.26%, 160 young women) said that a casual relationship had been responsible for conception. Such relationships are typically characterised by lower commitment and perhaps less discussion of contraceptive use and sexual health, behaviour that would increase the risk of unintended pregnancy.

Notably, 6.64% of adolescent mothers (39 young women) said that they had conceived as a result of defilement, which legally refers to any sexual contact with minors under the age of consent and is considered a criminal offence. This response underscores that sexual exploitation and abuse of adolescent mothers is a serious issue in Rwanda, highlighting the need for robust legal and social protection.

0.85% of adolescent mothers (5 young women) reported that the relationships that resulted in conception had been with a family member, implying incest. These cases are particularly concerning because such relationships characteristically involve abuses of power and coercion, for which carefully targeted interventions and support systems for victims are necessary.

2.21% of adolescent mothers (13 young women) indicated that an employer was responsible for conception, a scenario that again raises concerns about unequal power in the relationship and also potential exploitation in a place of work.

Another 3.75% of adolescent mothers (22 young women) said that conception had occurred during a single encounter; such encounters often do not discuss contraceptive use. A neighbour was the partner for 7.16% of adolescent mothers (42 young women), illustrating that sexual relationships are often very local. They may or may not lead to longer-term commitments or include discussion of contraception or reproductive responsibilities.

This mapping of relationship shows the social contexts in which adolescent women conceive. It reveals a spectrum of relationships, from ones that involve long commitment to ones that exploit and abuse. Each presents distinct challenges and requires different sexual health education and policy interventions. Programmes that aim to reduce adolescent pregnancy rates must consider these different relational contexts and tailor strategies that address the specific needs and vulnerabilities associated with each.

Marital status of the sexual partner

Table 10: Marital status of the sexual partner at the time of conception

Marital status	Number	%
Divorced	10	1.70
Married	66	11.24
Single	491	83.65
Don't know	20	3.41
Total	587	100.00

The marital status of the sexual partners of adolescent mothers at the time of conception reveals social and personal dynamics that can influence adolescent pregnancies. A significant majority of sexual partners (83.65%, 491 individuals) were single at the time of conception. The response suggests that most adolescent pregnancies occur in relationships in which neither partner is legally married.

11.24% of adolescent mothers (66 young women) said that their sexual partner at the time of conception was married to someone else. This introduces complex social issues, because such relationships are socially stigmatised and also raise legal concerns that may have adverse social and psychological consequences for the adolescent mother. The married men in these relationships may also exercise unequal power in the relationship, or exploit their adolescent partner, particularly if she is significantly younger.

A small fraction of adolescent mothers (1.70%, 10 young women) reported that their partners were divorced. This status might also bring complications, including past familial commitments and existing children. These could weaken the partner's support to and responsibility for the adolescent mother.

Overall, the marital statuses of partners illuminate some of the social and emotional contexts in which adolescent pregnancies occur. Each may influence the outcomes for, and experiences of, adolescent mothers. These factors need to be carefully considered when designing interventions to prevent adolescent pregnancy, because they affect the kinds of support that adolescent mothers require and the specific challenges they face during and after their pregnancy. To provide effective support and reduce the incidence of adolescent pregnancy, programmes need to address each situation on its merits.

Number of sexual partners before the (first) pregnancy

Table 11: Number of sexual partners before the (first) pregnancy

	Number	%
Five and above	8	1.36
Four	8	1.36
Three	21	3.58
Two	74	12.61
One	339	57.75
It was the first time	137	23.34
Total	587	100.00

The number of sexual partners that adolescent mothers had before their first pregnancy sheds light on the sexual behaviour of young women and the potential risks they face before they enter parenthood. A significant majority of adolescent mothers (57.75%, 339 young women) reported that they had only one sexual partner before becoming pregnant, which suggests a high level of relationship exclusivity or limited sexual experience prior to conception. This pattern may reflect cultural norms that value fidelity or may indicate that mothers had limited sexual experience before falling pregnant; both may be true.

Interestingly, 23.34% of adolescent mothers (137 young women) indicated that they became pregnant following their first sexual experience. This response further underlines the need for SRH education that encourages use of contraceptives and safe sex practices from the onset of sexual activity. The fact that nearly a quarter of the women became pregnant after their first sexual encounter further emphasises the degree to which many adolescent girls lack SRH awareness and access to contraceptives.

19.24% of adolescent mothers (113 young women) had had two or more partners before becoming pregnant, of whom 12.61% (74 individuals) had two partners, 3.58% (21 individuals) had three partners, and 2.72% (16 individuals) had four or more partners. These figures show that a relatively low proportion of adolescent mothers had had several sexual partners.

If they do not use contraceptives, members of this subgroup face a higher risk of contracting STIs and having more children without paternal support, potentially increasing their vulnerability and placing an additional burden on their families and the state.

This information provides an essential evidence base for public health initiatives that aim to reduce adolescent pregnancy and promote safer sexual practices. It highlights the importance of targeted interventions that address contraceptive use but also broader concerns of sexual education, such as relationship dynamics and sexual decision-making. To address their specific circumstances and needs, programme communications need to be sensitive to the sexual experience and sexual exposure of adolescents. It is vital to ensure that all young women have the knowledge and resources they need to navigate their sexual choices and health safely, irrespective of the number of their sexual partners.

Overall, the statistics reveal that, for most adolescent mothers, their first significant sexual relationship quickly transitions into parenthood. This highlights the need for comprehensive sex education that includes discussion of contraception, consent, and healthy (egalitarian) relationships. This approach would reduce the high number of conceptions that occur after a first sexual encounter and spread knowledge that would reduce unintended adolescent pregnancy more widely.

Antenatal care during pregnancy

Table 12: Do adolescent mothers benefit from antenatal care during pregnancy?

	Number	%
No	41	6.98
Yes	546	93.02
Total	587	100.00

A remarkably high proportion of adolescent mothers (93.02%, 546 individuals) made use of antenatal care (ANC) during their pregnancy. This suggests that the reach of ANC services is effective and possibly that adolescent mothers are well aware of the benefits of ANC, which plays an essential role in monitoring maternal and foetal health and interventions to prevent complications during pregnancy and childbirth.

Various factors explain the high use of ANC, including Rwanda's robust healthcare policies (which stress maternal and child health), well-developed community health initiatives, and possibly the role of local health workers in promoting and facilitating access to ANC services. Programmes often focus on the most vulnerable populations, including adolescents.

Nevertheless, a small but significant number of adolescent mothers (6.98%, 41 individuals) did not receive antenatal care. This is concerning because it highlights a gap in healthcare access or uptake that exists for a spread of reasons, including geographical barriers, socio-economic constraints, lack of information, and cultural beliefs that deter girls from seeking formal medical care during their pregnancy.

ANC interventions need to reach all adolescent mothers, particularly young women who are at risk of being left out of the healthcare system. Ensuring that every adolescent mother receives antenatal care is a crucial component of efforts to improve birth outcomes and reduce maternal and infant mortality rates.

Overall, the high use of ANC services is a positive indicator of the effectiveness of Rwanda's maternal healthcare. Nevertheless, these services must continue to eliminate barriers and enhance their quality and reach, to ensure that every adolescent mother has the support she needs for a healthy pregnancy and delivery. Table 13 examines the number of ANC appointments that pregnant adolescents attended.

Table 13: Frequency of antenatal care appointments

Frequency	Number	%
Less than 3 times	113	20.70
3 to 5 times	384	70.33
6 times	49	8.97
Total	546	100.00

The number of ANC visits that adolescents made during their pregnancy indicates how much healthcare they received. A large majority (70.33%, 384 young women) attended between 3 and 5 times. This level of attendance approaches the World Health Organization's recommendations for a healthy pregnancy, which call for at least eight visits (WHO, 2018, p. 1). It indicates that the majority of adolescent mothers adhere to prenatal care guidelines, and that Rwanda's maternal health services are broadly both accessible and effective.

However, there were notable variations in the frequency of visits. One in five adolescent mothers (20.70%, 113 young women) had fewer than three ANC visits, which is below the number that ensures optimal maternal and foetal health monitoring. These mothers may have been deterred by poor accessibility or socio-economic barriers, or been unaware of the importance of regular ANC visits.

At the other end of the spectrum, 8.97% of adolescent mothers (49 young women) attended six times. This higher engagement could indicate that their pregnancies were high-risk and needed more frequent monitoring, or that these mothers were more health conscious and committed to prenatal care.

The data show the importance of targeted health education and outreach programmes, particularly for mothers who are less likely to attend ANC visits. Enhancing education on the benefits of regular ANC could increase attendance rates, especially by women who have limited access to healthcare or lower health literacy. It is equally important to remove logistical and financial barriers that prevent women from making ANC visits. All pregnant adolescents should be able to benefit from the full spectrum of prenatal care services. An inclusive and proactive strategy will improve health outcomes for both mothers and their babies and also contribute to the achievement of broader public health goals, including the reduction of maternal and infant morbidity and mortality.

Childbirth facilities

Table 14: The delivery facilities used by adolescent mothers

Facility	Number	%
Home	9	1.53
Hospital/health centre	576	98.13
Traditional healer	2	0.34
Total	587	100.00

Where adolescent mothers deliver their babies is an indicator of the healthcare system's reach and illuminates the choices that young women make when they give birth. The overwhelming majority of adolescent mothers (98.13%, 576 young women) reported that they gave birth in a hospital or health centre. This is strong evidence of the effectiveness of Rwanda's community mobilisation and awareness campaigns. Often spearheaded by community health workers (*Abajyanama b'ubuzima*), these emphasise the importance of giving birth in medically supervised environments to ensure that both mother and child are safe.

This response also confirms that Rwanda's health policies are effective and that its network of community health workers do indeed play a pivotal role in educating and guiding expectant mothers. These workers promote antenatal care and safe delivery practices in the community and help to ensure that pregnant women, including adolescent mothers, are aware of and can access medical services they need.

A small proportion of adolescent mothers nevertheless chose alternative locations. 1.53% (9 young women) gave birth at home; and 0.34% (2 young women) used the services of traditional healers. These choices may have been due to cultural beliefs, geographical barriers, or personal preference. The persistence of such minority choices indicates that improvements in public health outreach can still be made. It remains important to ensure that no woman is unable to access safe childbirth facilities.

Rwanda's use of community health workers to extend its health education and health services is a model of how community-driven initiatives can improve health outcomes. By continuing to strengthen these efforts and

ensuring that all pregnant women have access to and choose medically supervised delivery settings, Rwanda can further improve maternal and neonatal health outcomes across the country.

Complications experienced during pregnancy or delivery

Table 15: Did you experience complications during pregnancy or delivery?

	Number	%
No	446	75.98
Yes	141	24.02
Total	587	100.00

Complications experienced during pregnancy or delivery are an indicator of the health challenges faced by adolescent mothers in Rwanda. 24.02% of the adolescent mothers who participated in this study (141 young women) experienced complications during their pregnancy or delivery. This figure highlights the vulnerabilities and health risks associated with adolescent pregnancy, which can be exacerbated by inadequate prenatal care, nutritional deficiencies, or the physical immaturity of younger mothers.

A large majority (75.98%, 446 young women) reported no complications, which may reflect positively on Rwanda's healthcare system, and particularly its ANC services. The high percentage of adolescent mothers who reported no complications suggests that, when prenatal care is accessed, it reduces or removes many of the risks associated with pregnancy and childbirth in young women.

Nevertheless, the fact that nearly one-fourth of adolescent mothers experienced complications underscores the need for healthcare interventions for this vulnerable group. Interventions might include enhanced prenatal screening programmes, more comprehensive education on maternal health, and reinforced pregnancy support services. Addressing the broader social and educational factors that contribute to adolescent pregnancy can help to reduce the incidence of complications by delaying the age of first pregnancy and can improve overall maternal health outcomes.

The 24.02% of adolescent mothers who experienced complications require particular attention from health policymakers and practitioners. This statistic is a reminder of the risks associated with adolescent pregnancy, but also highlights that the healthcare system needs to improve its support mechanisms for young mothers to ensure that they have a safe pregnancy and delivery. Ensuring that adolescent mothers have adequate access to information, healthcare services, and support will reduce the number of complications and promote the health of both mothers and their infants.

4.4 Psychosocial factors contributing to adolescent pregnancies

This section explores psychosocial factors that particularly affect adolescent mothers and contribute to adolescent pregnancy in Rwanda. It examines several psychosocial variables, including parenting styles, adolescent participation in decision-making, peer pressure, and mental ill-health (PTSD, depression and anxiety), among other relevant factors, and applies regression analysis to measure their association with adolescent pregnancy. The analysis throws light on factors that shape the sexual and reproductive health and behaviours of female adolescents in Rwanda.

4.4.1 Prevalence of selected psychosocial variables among adolescent mothers and non-mothers

4.4.4.1 Parenting styles

Table 16: The parenting styles of adolescent mothers'[9] and non-mothers' families

Parenting styles		Adolescent non-mothers	Adolescent mothers	Total
Authoritative - warmth and support	No	106 (18.31)	227 (40.46)	333 (29.21)
	Yes	473 (81.69)	334 (59.54)	807 (70.79)
Authoritative - regulation	No	130 (22.45)	243 (43.31)	373 (32.72)
	Yes	449 (77.55)	318 (56.69)	767 (67.28)
Authoritative - autonomy-granting	No	183 (31.62)	312 (55.65)	495 (43.42)
	Yes	396 (68.38)	249 (44.35)	645 (56.58)
Authoritarian - verbal hostility	No	226 (39.01)	216 (38.50)	442 (38.68)
	Yes	353 (60.99)	345 (61.50)	698 (61.32)
Authoritarian - physical coercion	No	462 (79.73)	450 (80.18)	912 (79.89)
	Yes	117 (20.27)	111 (19.82)	228 (20.11)
Permissive - indulgent	No	348 (60.14)	396 (70.62)	744 (65.26)
	Yes	231 (39.86)	165 (29.38)	396 (34.74)

To analyse the parenting styles of families of adolescent mothers and adolescent non-mothers in Rwanda the research team used a Likert scale, in which 'Yes' responses indicate frequencies of 'Always', 'Very often', and 'About half the time' and 'No' responses indicate frequencies of 'Once in a while' and 'Never'. This approach highlights the regularity and consistency of specific parenting behaviours that influence adolescent behaviours and outcomes.

A comparison of the parenting styles of families of adolescent mothers and families of adolescent non-mothers throws light on the familial influences that shape adolescent outcomes and behaviours. It helps to explain how young women reach decisions about and manage their sexual and reproductive health.

Authoritative parenting. Authoritative parenting is known to have a positive impact on child development. The distribution varied between the two groups. 81.69% of adolescent non-mothers reported receiving warmth and support from their parents, whereas only 59.54% of adolescent mothers did so. This disparity suggests that adolescent non-mothers are more likely to benefit from supportive and nurturing home environments, which can enhance their self-esteem and decision-making abilities, potentially leading to lower rates of adolescent pregnancy.

In terms of regulatory behaviours within authoritative parenting, 77.55% of adolescent non-mothers reported that they had experienced clear rules and structure at home, compared to only 56.69% of adolescent mothers. The absence of such regulation in the lives of adolescent mothers may contribute to risky behaviours, including early sexual activity and failure to use contraceptives. Both practices increase pregnancy rates.

9 Adolescent mothers were asked what parenting styles they experienced before they started the sexual activity that resulted in their pregnancy.

The two groups also differed in their experience of autonomy-granting parenting. 68.38% of adolescent non-mothers reported that their parents allowed them to take decisions, whereas 44.35% of adolescent mothers did so. A lack of autonomy in adolescent mothers' lives may prevent them from making informed and empowered choices about their sexual health, elevating their risk of pregnancy.

The authoritarian parenting style. Characterised by verbal hostility and physical coercion, this parenting style was experienced more evenly by the two groups. It was alarmingly high in both. About 61% of adolescent mothers and adolescent non-mothers reported experiencing verbal hostility, and around 20% had experienced physical coercion. These results suggest that harsh disciplinary practices are widespread in Rwanda. Such practices harm adolescents' psychological health and can lead to maladaptive behaviours, some of which increase the risk of pregnancy.

Permissive parenting. Marked by indulgence and lack of discipline, this form of parenting was reported more frequently by adolescent non-mothers than by adolescent mothers, indicating that adolescent mothers may have more restrictive and less communicative family environments. This could reduce their opportunities to discuss sexual health topics, which would increase their risk of unintended pregnancy.

Overall, the differences in parenting styles between adolescent mothers and adolescent non-mothers highlight crucial areas for intervention. Programmes that disseminate positive parenting practices are essential, to improve communication and SRH education, and promote home environments that empower young women to make safer, more informed choices. Addressing these parenting differences can reduce adolescent pregnancy rates and enhance the overall wellbeing of young women in Rwanda. Such efforts should be integrated in broader public health and educational strategies that create supportive, informed communities in which adolescent girls can thrive.

4.4.4.2 The participation of adolescent mothers and adolescent non-mothers in decisions that affect their lives

Adolescent participation in individual and inter-personal decision-making is a marker of maturity and therefore helps to prevent adolescent pregnancies and risky sexual behaviours. Individually, it empowers adolescents to make informed choices about their own health and relationships. Inter-personally, it fosters open communication between peers, parents, and educators, creating a supportive environment for discussing issues of importance. Such an environment helps adolescents to take sound decisions about their sexual health and reduce risky behaviours. Table 17 shows the answers that adolescents in the study gave when they were asked whether they agreed or disagreed that they participated in making decisions.

Table 17: Do adolescent mothers[10] and adolescent non-mothers participate in decisions that affect their lives?

	Adolescent non-mothers	Adolescent mothers	Total
Agree	326 (55.54)	270 (46.00)	596 (50.77)
Disagree	66 (11.24)	118 (20.10)	184 (15.67)
Neutral	195 (33.22)	199 (33.90)	394 (33.56)
Total	587 (100)	587 (100)	1174 (100)

The data set out in Table 17 were also analysed using a Likert scale, according to which 'Agree' covers respons-

10 Adolescent mothers were asked to say whether they participated in decision-making before they began the sexual activities that resulted in pregnancy.

es from 'Strongly agree' to 'Agree', and 'Disagree' covers responses from 'Disagree' to 'Strongly disagree'. It shows that adolescent non-mothers and adolescent mothers differed in their perceptions.

55.54% of adolescent non-mothers agreed that they were involved in decisions that affected their lives, suggesting a relatively high level of perceived autonomy. It is likely that this group of adolescents benefits from an environment that supports and encourages active participation in significant life choices, which can positively influence their behaviour and decision-making in the areas of sexual health and relationships.

Conversely, only 46% of adolescent mothers felt that they had a say in decision-making before their pregnancies. Their response reveals a concerning gap in their perceived control over their lives. A belief that they lack autonomy could have influenced how they entered into sexual relationships and became pregnant, and could imply that they were less able to negotiate safe sexual practices or resist pressure to engage in early sexual activity.

These differences are reproduced in the 'Disagree' response: more adolescent mothers (20.10%) than adolescent non-mothers (11.24%) disagreed that they participated in decisions. A significant proportion of adolescent mothers felt sidelined, which may correlate with lower ability to take responsibility, act with autonomy, and manage risks.

A rather high proportion, about one third of both groups, did not express a view. Their neutrality suggests that several factors influence their involvement in decision-making. Their ambivalence may indicate that adolescents feel empowered in some areas of their lives but not in others, and particularly not in contexts that traditionally involve more adult intervention or oversight.

In conclusion, it will be important to develop strategies that enhance the decision-making abilities of adolescents, particularly those at risk of early pregnancy. An environment that supports informed and autonomous decision-making by all adolescents, notably before they become sexually active, can equip them to make choices that lead to healthier and more empowered lives. Addressing this need involves educational interventions but also broader community and policy initiatives that reshape societal attitudes to adolescent autonomy and sexual health.

4.4.4.3 Peer pressure experience

Table 18: Frequency of peer pressure experience among adolescent mothers and non-mothers[11]

	Adolescent non-mothers	Adolescent mothers	Total
Always	3 (0.51)	21 (3.58)	24 (2.04)
Sometimes	201 (34.24)	219 (37.31)	420 (35.78)
Never	383 (65.25)	347 (59.11)	730 (68.18)
Total	587 (100.00)	587 (100.00)	1174 (100.00)

The data provide a comparative analysis of the experience of peer pressure of adolescent mothers and non-mothers. Adolescent mothers reported experiencing peer pressure more frequently than their non-mother counterparts. Specifically, 3.58% of adolescent mothers reported always experiencing peer pressure,

11 Each group was asked to comment on nine items that measured peer pressure. Adolescent mothers reported on experiences before they began the sexual activity that caused their pregnancy. Non-mothers reported on their experiences in the last 30 days. The table sets out aggregated data for all nine items.

compared to only 0.51% of non-mothers. This disparity suggests that persistent peer pressure may be more pronounced among adolescent mothers, potentially influencing behaviours and decisions that can lead to early pregnancy.

Both groups reported experiencing peer pressure "sometimes". 37.31% of adolescent mothers and 34.24% of non-mothers did so. While the difference is less pronounced, it highlights that occasional peer pressure is common among adolescents but may have more influence on those who ultimately become mothers. This finding raises questions about the incremental effects of peer pressure over time and its role in shaping reproductive decisions.

The majority of adolescents in both groups reported that they had not experienced peer pressure. 65.25% of non-mothers and 59.11% of mothers indicated that they were not influenced by their peers. This difference suggests that lack of peer pressure may protect against adolescent pregnancies. The higher proportion of non-mothers who reported no peer pressure highlights the importance of creating environments that foster independent decision-making and shield young people from undue social influence.

While this analysis sheds light on differences in the experiences of peer pressure of adolescent mothers and non-mothers, it does not establish a causal relationship between peer pressure and adolescent pregnancy. The association between peer pressure and adolescent pregnancy is explored in a separate section of the study (see Table 22). The data set out in Table 18 show the varying social dynamics faced by these two groups and invites further investigation.

The findings underscore the importance of addressing peer pressure as part of a broader preventive strategy. Tailored programmes that build resilience, critical thinking, and decision-making skills among adolescents can help to mitigate the negative effects of peer influence. Additionally, fostering positive peer interactions and empowering adolescents to make independent choices reduce the risks associated with peer pressure.

4.4.4.4 PTSD

Table 19: The prevalence of PTSD among adolescent mothers and adolescent non-mothers

	Adolescent non-mothers	Adolescent mothers	Total
No symptoms	507 (86.37)	395 (67.29)	902 (76.83)
Relevant symptoms	80 (13.63)	192 (32.71)	272 (23.17)
Total	587 (100.00)	587 (100.00)	1174 (100.00)

Table 19 reveals a stark difference between adolescent non-mothers and adolescent mothers. Whereas 13.63% of adolescent non-mothers exhibit symptoms of PTSD (a very high rate in most contexts), no less than 32.71% of adolescent mothers do so. More than twice as many adolescent mothers have been exposed to and show symptoms of traumatic stress, highlighting the profound impact that adolescent pregnancy and motherhood can have on mental health. The differences are likely to be due to fewer life disruptions, the stress of bringing up a child at a young age, social isolation, and the stigma associated with being a young mother.

The elevated stress of adolescent mothers indicates that targeted psychosocial interventions are needed to support them. The data suggest that, while general mental health support is crucial, services are required that specifically address the unique challenges and traumas faced by adolescent mothers. Such interventions could include specialised counselling, support groups for young mothers, and community education programmes that tackle the stigma that exacerbates their psychological distress.

4.4.4.5 Depression

Table 20: The prevalence of depression among adolescent mothers and adolescent non-mothers

	Adolescent non-mothers	Adolescent mothers	Total
Probably not depressed	481 (81.94)	401 (68.32)	882 (75.13)
Moderate depression	106 (18.06)	177 (30.15)	283 (24.11)
Severe depression	0 (0.00)	9 (1.53)	9 (0.76)
Total	587 (100.00)	587 (100.00)	1174 (100.00)

Adolescent mothers and adolescent non-mothers show a sharp difference in levels of depression. More adolescent mothers are depressed.

30.15%, nearly one third, of adolescent mothers are moderately depressed, compared with 18.06% of adolescent non-mothers. This is further evidence of the additional psychological strain placed on adolescent mothers. Factors that contribute may include the stress of parenting responsibilities, parents' negative reactions to their pregnancy, the social stigma associated with early motherhood, and the economic burdens of raising a child. The fact that their rate of moderate depression is nearly twice that of adolescent non-mothers suggests that the challenges associated with adolescent motherhood contribute significantly to their mental health struggles.

The data on severe depression are even more concerning. 1.53% of adolescent mothers experienced severe symptoms, whereas no case of severe depression was reported by non-mothers. This is further evidence of the psychological distress that some adolescent mothers face. That severe depression is confined to this group points to the acute challenges they encounter, which can include pronounced social isolation, financial hardship, and poor access to resources or coping mechanisms.

These findings further confirm that targeted mental health interventions are needed that specifically support adolescent mothers. Support systems should address the general mental health needs of all adolescents but must specifically tackle the severe challenges faced by young mothers. Enhancing access to mental health services, providing community-based support programmes, and integrating mental health care in maternal and child health services are three steps that can be taken to improve the overall wellbeing of adolescent mothers and mitigate their high rates of depression.

4.4.4.6 Anxiety

Table 21: The prevalence of anxiety in adolescent mothers and adolescent non-mothers

	Adolescent non-mothers	Adolescent mothers	Total
No anxiety	357 (60.82)	224 (38.16)	581 (49.49)
Mild anxiety	191 (32.53)	245 (41.74)	436 (37.14)
Moderate anxiety	39 (6.65)	102 (17.38)	141 (12.01)
Severe anxiety	0 (0)	16 (2.72)	16 (1.36)
Total	587 (100.00)	587 (100.00)	1174 (100.00)

The data on anxiety levels show significant differences in mental health outcomes between adolescent mothers and adolescent non-mothers, further confirming the added psychological strains that adolescent mothers face. Motherhood clearly increases the anxiety of adolescents.

60.82% of adolescent non-mothers, but only 38.16% of adolescent mothers, reported having no anxiety symptoms. A significantly smaller proportion of adolescent mothers experience no anxiety. The additional stress factors associated with adolescent motherhood include societal stigma, financial pressures, and the responsibilities of parenthood. Each of these can contribute to mental health challenges.

32.53% of adolescent non-mothers reported mild anxiety, whereas 41.74% of adolescent mothers did so. This result suggests that adolescent mothers are more likely to experience ongoing but manageable levels of anxiety, possibly linked to the ongoing demands and uncertainties of motherhood and the impact of adjusting to life with a new child.

The gap is even more pronounced when it comes to moderate anxiety. 6.65% of adolescent non-mothers reported moderate anxiety whereas 17.38% of adolescent mothers did so. This gap raises a more significant mental health concern, because moderate anxiety can interfere with a person's daily functioning and wellbeing.

Severe anxiety was reported only by adolescent mothers (2.72%). Severe anxiety has a serious impact on a person's daily life and psychological health. The absence of severe anxiety in the non-mother group further confirms that adolescent mothers face specific and significant vulnerabilities.

Overall, these findings reveal that adolescent mothers are more likely to experience anxiety than adolescent non-mothers, at all levels. This suggests that targeted mental health interventions are needed to address and mitigate the specific stressors that cause anxiety among adolescent mothers. Such interventions could include accessible mental health services, community support programmes, and educational initiatives that reduce stigma and provide practical support.

4.4.2 Psychosocial factors that contribute to adolescent pregnancy

This section analyses psychosocial factors that contribute to adolescent pregnancy in Rwanda, including knowledge of sexual and reproductive health, contraceptive use, parenting styles, and peer pressure. It employs logistic regression to quantify their impacts.

Table 22: Psychosocial factors that contribute to adolescent pregnancy (logistic regression)

Give birth or not	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
SRH	-1.537	.141	-10.94	0	-1.813	-1.262	***
Thought of using contraceptive	-2.58	.249	-10.35	0	-3.069	-2.092	***
Authoritative: warmth and support	-.037	.018	-2.08	.037	-.073	-.002	**
Authoritative: regulation	-.016	.023	-0.70	.485	-.062	.03	
Authoritative: autonomy-granting	-.02	.022	-0.91	.362	-.063	.023	
Authoritarian: verbal hostility	-.018	.029	-0.63	.528	-.074	.038	
Authoritarian: physical coercion	.07	.033	2.13	.033	.006	.134	**

Give birth or not	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Permissive: indulgent	.155	.034	4.54	0	.088	.222	***
Adolescent participation in decision-making	.016	.014	1.11	.265	-.012	.044	
Peer pressure	.129	.023	5.71	0	.085	.174	***
Number of observations 1140		*** p<.01, ** p<.05, * p<.					

The logistic regression results revealed that SRH knowledge significantly reduces the likelihood of giving birth. Adolescents with better SRH knowledge are less likely to experience pregnancy. The coefficient for SRH is -1.537 ($p < 0.001$), with an odds ratio (OR) of approximately 0.215, indicating that higher levels of SRH knowledge substantially decrease the odds of becoming pregnant. Specifically, adolescent women with SRH knowledge are 78.5% less likely to become pregnant than adolescent women with no SRH knowledge.

The results confirm a significant negative association between thinking about using contraceptives and the likelihood of giving birth. The coefficient of -2.58, which translates to an OR of approximately 0.076, suggests that adolescents who consider using contraceptives are about 92.4% less likely to conceive than those who do not consider using contraceptives.

In terms of parenting styles, the authoritative style (warmth and support) shows a significant negative relationship with the likelihood of giving birth. For each unit increase in warmth and support, the odds of giving birth decrease by approximately 3.6%. Furthermore, the results indicate that authoritarian physical coercion and permissive indulgent parenting both play significant roles in adolescent pregnancy.

Authoritarian physical coercion is positively associated with pregnancy, with a coefficient of 0.07 ($p < 0.05$) and an OR of approximately 1.07. This suggests that higher levels of physical coercion by authoritarian parents are associated with higher chances of becoming pregnant. Adolescent girls who experience physical coercion at the hands of authoritarian parents are 7% more likely to become pregnant than girls who do not experience that parenting style.

Permissive parenting (indulgent) is also positively associated with pregnancy status, having a coefficient of 0.155 ($p < 0.001$) and an OR of approximately 1.16. Permissive parenting significantly increases the likelihood of giving birth. Adolescents who experience indulgent parenting are 16% more likely to fall pregnant.

Peer pressure emerges as a significant risk factor for adolescent pregnancy. The coefficient for peer pressure is 0.129 ($p < 0.001$), with an OR of approximately 1.14, suggesting that increased peer pressure raises the odds of being pregnant by about 14%. This highlights the influential role of peers. Adolescents who experience higher peer pressure are more likely to become pregnant.

In summary, the analysis reveals that SRH knowledge, certain parenting styles (authoritative warmth and support, authoritarian physical coercion, and permissive indulgent), and peer pressure are significant predictors of adolescent pregnancy in Rwanda. Specifically, SRH knowledge reduces the likelihood of pregnancy, while peer pressure and some parenting styles increase it.

Other factors that drive adolescent pregnancy

Economic hardship (individual and household)

Participants in focus group discussions frequently said that economic hardship is a primary catalyst of adolescent pregnancy. During FGDs, adolescent mothers often said that economic insecurity influenced their decision to enter relationships that might lead to pregnancy. These young women, along with their families, face significant financial pressures that sometimes push them to seek economic support through relationships. Opinion leaders and parents corroborated their remarks and emphasised that economic empowerment initiatives were needed that would give adolescents skills and opportunities for self-sufficiency. By promoting economic independence, communities can significantly mitigate pressures that lead to adolescent pregnancy.

Parents who struggle to earn a livelihood have limited time for their children

The focus group meetings revealed that many parents and guardians are concerned that, because they are compelled for economic reasons to spend a lot of time away from home, they leave their adolescent children unsupervised. These parents acknowledged that their absence increased the likelihood that their children would engage in risky behaviours, including premature sexual activity. For instance, participants in FGDs and KIIs in Rubavu District said:

> *Many parents are compelled by economic pressures to leave home early and return late, often crossing into Goma [Democratic Republic of Congo] for work. This prolonged absence from home not only strains family relationships but leaves adolescents without necessary supervision, increasing their vulnerability to engaging in risky behaviours, such as premature sexual activities. (Gender Officer, Rubavu District .)*

> *One of the reasons that contribute to children being impregnated prematurely includes parents not fulfilling their parental responsibilities. For instance, when you observe, as the child grows, you notice the parent is not attentive. For example, where we live, a parent might wake up early and go to Congo to trade, leaving the child unsupervised all day, not knowing where the child has been, who they spent the day with, or what behaviours the child is picking up. The parent returns at night, oblivious to where the child has been, and the child grows up having to fend for herself, seeking a means of survival. As the child grows and her needs increase, when she meets someone who offers her small favours, those little bribes, let's say, that's how she gets pregnant, the child then enters that way of life. (Male parent, FGD, Rubavu District.).*

Such lifestyles leave little to no room for meaningful interaction between parents and their children, though it plays a crucial role in guiding them through adolescence. In discussions, several participants described instances where the absence of parental guidance had led to adolescent pregnancy because young people lacked the necessary oversight and support from their guardians.

To address these challenges, participants called for the establishment of more robust community engagement programmes. These would provide adolescents with safe spaces in which they could take part in structured activities, receive mentorship, and access information on sexual and reproductive health. By filling the supervision gap left by parents who are busy finding an income, such initiatives could significantly decrease the likelihood that adolescents will engage in risky behaviours and become pregnant.

Enhancing local support systems in such ways would provide direct supervision but also build a framework of community responsibility for nurturing and guiding its youth. This would alleviate some of the burdens on parents and promote a communal environment in which adolescents could develop in healthy ways.

Intrafamily conflicts

Intrafamily conflicts and dysfunctions contribute significantly to the incidence of adolescent pregnancy in Rwanda. They include marital disputes leading to intimate partner violence; parental substance abuse, such as drunkenness; poor parenting practices; and generational clashes between parents and children. Participants in both FGDs and KIIs suggested that marital conflicts, often characterised by intimate partner violence, create a disruptive and unsafe home environment for adolescents. An atmosphere of continual conflict and instability can drive adolescents to seek comfort and escape in external relationships, which are not always protective or healthy.

> *My pregnancy was influenced by the father of my baby providing the support that my parents could not. When I needed school materials and asked my mother, she told me to ask my father, who dismissed me with insults and demeaning labels like 'akavuro', telling me I would accomplish nothing in life. This rejection led me to seek material support elsewhere, which ultimately resulted in my pregnancy. (Adolescent mother, FGD, Nyagatare District.)*

> *Our family life is often marked by violence and conflict. My pregnancy was caused by my mother's husband (not my biological father). One evening, he returned home drunk, around 9:30 pm and abruptly forced us out. Given the circumstances, my mother suggested I spend the night at the house of a nearby friend, who was experiencing similar issues. I went there with my younger sibling, only to find my friend in her living room with several intoxicated male acquaintances. Despite knowing these boys, I reassured them that I do not drink alcohol and was content just sitting with them. As the evening progressed, they offered to buy me a soda, which unbeknown to me they spiked with a pill. After drinking it, they showed me where I could sleep. The next morning, I woke up feeling altered and noticed blood on me. When I confronted my friend about potentially being assaulted, she questioned my naivety and dismissively implied that I should have been aware of the risks. Distressed, I returned home and shared the ordeal with my mother, who promptly took me to the Rwanda Investigation Bureau (RIB). I also visited the Isange One Stop Centre in Gisenyi for a medical examination, where they scheduled a follow-up in three months. During this period, I experienced aversion to certain foods, and, on returning for my check-up, I discovered I was pregnant. (Adolescent mother, 17 years old, FGD, Rubavu District.)*

Participants added that poor parenting and conflicts between parents and children exacerbate the risk factors associated with adolescent pregnancy. In homes where effective communication and nurturing care are absent, adolescents often struggle with low self-esteem and inadequate knowledge of sexual health, making them vulnerable to exploitative relationships. The consumption of alcohol by parents not only impairs their ability to provide a stable upbringing but often leads to neglect, further alienating their children. These complex family dynamics require comprehensive, community-based interventions that include family counselling, parental education programmes, and youth empowerment initiatives. Such measures can help mend the fabric of family relations and provide adolescents with the resilience and support they need to manage their developmental years without resorting to risky behaviour.

Forced sexual intercourse:

Forced sexual intercourse is a cause of adolescent pregnancy in Rwanda. It occurs when adolescents are forced to participate in sexual activity without their consent. Such acts are criminal in law and ethically indefensible. According to Rwandan law, any sexual activity involving individuals under the age of 18 is classified as defilement, on the grounds that minors are legally unable to give consent. This legal framework is designed to protect minors from sexual exploitation and abuse, and reflects the country's commitment to safeguarding the rights and welfare of its young people.

During focus group discussions, adolescent mothers reported that forced sexual intercourse was a significant concern. Participants described cases where some adolescents were forced to engage in sexual intercourse in dark corners, bedrooms or after drinking alcohol. Some adolescent pregnancies result from such coercive and non-consensual encounters, which are often perpetrated by individuals in their community or known to the family.

> *I was employed at a home in Kimisagara, Kigali, working for a couple and their 23-year-old son who was usually at school until 10 pm. In my second month of employment, the parents bought me a phone worth FRW 5,000 so I could call them in case of any issues. However, the son started using this phone to call his friends. One evening around 6 pm, he came into my room and locked the door, threatening to harm me with a kitchen knife unless I complied with his demands. He attempted to force himself on me, threatening further violence if I resisted. Terrified, I pleaded for a moment to think, hoping to calm the situation. When he momentarily stepped outside, I planned to escape but found myself trapped. He returned, assaulted me, and destroyed my clothes with a razor. Overwhelmed and desperate, I managed to reach the RIB in Nyarugenge, Kigali. After changing into fresh clothes, I reported the incident. The RIB responded promptly, contacting his parents who were unaware of the events as they had been attending a funeral.*
>
> *Upon their return, they refused to believe my account, accusing me of misconduct instead. The situation escalated when the father promised retribution, blaming me for the incident. Following this traumatic experience, I felt compelled to flee my family home for safety. A couple of days later, I noticed that I was pregnant. (Adolescent mother, 17 years old, FGD, Rubavu District.)*

Social stigma and family pressure after such incidents can further isolate the victim, compounding her trauma and her decisions about the pregnancy. Action to stop forced sexual intercourse and its impact on adolescent pregnancy must be concerted, and must enhance protection of young people, improve legal and social support, and foster a community environment that supports rather than stigmatises victims.

Side effects of digital tools

The double-edged impact of digital tools (smart phones, social media) was discussed extensively in focus groups. Adolescents described the benefits of connectivity but also the risks, including exposure to harmful content and pressure to conform to behaviour seen online. Parents and guardians and opinion leaders expressed concern about the lack of control and supervision of digital content, especially pornographic films and videos.

> *My colleague has made a good point about parents neglecting their responsibilities, but I would like to specifically address these children. In this era, we still face a problem with technology, which on one side is good, but also problematic. For instance, often a young girl, due to her physical development, might be watching pornographic films and other similar content. Many of them own mobile phones, and on these phones, sometimes they access content that is both good and bad. Those pornographic films they watch, all that stuff, as she keeps watching things that are not suitable for her age or her developmental stage, eventually, she might want to put what she's seen into practice. (Male opinion leader, FGD, Rubavu District.)*

Participants called for comprehensive digital literacy programmes that will teach adolescents how to navigate online spaces safely and make informed decisions about the content they watch. Enhancing digital literacy could mitigate the negative impacts of digital exposure, including peer pressure and exposure to sexual content, both of which are linked to adolescent pregnancy

Males are not sufficiently involved in preventing adolescent pregnancy

The failure of men to act responsibly or help sufficiently to prevent adolescent pregnancy significantly contributes to its prevalence. Traditionally, sexual and reproductive health (SRH) initiatives targeted women and girls. They frequently overlooked the critical role that men and boys play. This oversight results in significant gaps in mutual understanding of contraception, sexual consent, and equitable relationships. Discussants in FGDs and KIIs consistently said that it was a mistake to exclude males from SRH education and community interventions because doing so closed off an opportunity to challenge entrenched gender norms and behaviours that contribute to adolescent pregnancy.

In the absence of male participation, the burden of contraception and pregnancy prevention falls almost entirely on young women. This is unjust, but also sustains societal norms that ignore male accountability or men's reproductive responsibilities. Without active male participation, crucial conversations about contraceptive use and sexual health often do not occur, leading to misinformation, misunderstandings or failures of communication. This increases the likelihood of unprotected sex and unintended adolescent pregnancy.

In addition, the exclusion of males from educational initiatives on sexual and reproductive health perpetuates gender stereotypes and power imbalances which can pressure young women into non-consensual or unprotected sexual encounters. Young men, if not properly educated about their roles and responsibilities, are likely to prioritise their personal pleasure over mutual safety and undermine efforts to promote contraceptive use. Societal structures that do not include young men in discussions of sexual responsibility also reinforce the stigmatisation and isolation of young women who become pregnant, making it harder for them to seek and receive support. Involving men and boys in prevention strategies will not only help to redistribute responsibilities more fairly but enhance the effectiveness of sexual health strategies by fostering a more supportive and equitable social environment.

To effectively address and reduce unintended pregnancies, it is crucial to actively involve men and boys in comprehensive educational efforts, encourage their participation in advocacy and peer mentoring programmes, and engage them in community-led dialogues to shift cultural perceptions towards gender equality and shared responsibility for reproductive health. This more inclusive approach can help to ensure that preventive measures resonate more broadly in the community, fostering an environment that supports informed and respectful decisions by all individuals involved.

Overall, interventions that integrate the insights of these focus group discussions can directly address many of the challenges that contribute to adolescent pregnancy. Community-guided preventive strategies and support systems are more likely to be relevant and will also be culturally sensitive and grounded in the real-world experiences of the individuals who are most affected.

4.5 The psychosocial effects of adolescent pregnancy on adolescent mothers and their families

This section examines the psychosocial effects of adolescent pregnancy on young mothers, focusing on PTSD, depression, and anxiety. It underscores the need for comprehensive support systems to address the mental health challenges these young women face. Drawing on quantitative data and qualitative insights, it finds that pregnancy has a significant impact on adolescent mothers' psychological wellbeing and a profound effect on their parents and relatives. The section draws on FGDs and KIIs to explore parental reactions and other psychosocial effects and understand the broader impact on families.

4.5.1 Psychosocial effects of pregnancy on adolescent mothers

This section examines the impact on adolescent mothers of PTSD, depression, and anxiety, and compares it to the experience of adolescent non-mothers. The analysis incorporates data from both groups and applied multinomial logistic regression to identify psychosocial effects due to pregnancy and childbirth.

Table 23: Psychosocial effects of pregnancy on adolescent mothers (multinomial logistic regression)

	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
PTSD (relevant symptoms)							
Give birth or not	1.125	.149	7.55	0	.833	1.417	***
Moderate depression							
Give birth or not	.695	.14	4.95	0	.42	.969	***
Severe depression							
Give birth or not	15.516	712.168	0.02	.983	-1380.307	1411.339	
Mild anxiety							
Status	.715	.129	5.55	0	.463	.967	***
Moderate anxiety							
Give birth or not	1.428	.207	6.91	0	1.023	1.833	***
Severe anxiety							
Give birth or not	16.071	611.835	0.03	.979	-1183.104	1215.246	
Number of observations	1174	*** p<.01, ** p<.05, * p<.1					

The analysis examined the effects of adolescent pregnancy on the mental health and wellbeing of adolescent mothers, focusing specifically on levels of PTSD, depression and anxiety.

The results show that an adolescent woman who becomes pregnant is significantly more likely to experience higher levels of PTSD. The coefficient (status) is 1.125 ($p < 0.001$), indicating a strong positive association between being pregnant and higher PTSD levels. The odds ratio (OR) for this coefficient is approximately 3.081, which indicates that adolescent mothers are more than three times as likely to experience elevated PTSD symptoms than adolescent non-mothers. This finding confirms that adolescent pregnancy has a profound impact of on the mental health of young mothers.

The results also show that there is a statistically significant positive association between being pregnant and higher levels of depression. The OR associated with this coefficient is approximately 2.004, suggesting that, compared to adolescent non-mothers, adolescent mothers are about twice as likely to experience moderate levels of depression.

> *After becoming pregnant, everything changed—it felt like the sky had fallen on me. I experienced intense anger and trauma. My family rejected me, and accepting myself became a struggle. Whenever I tried to explain, they would say, "How did you end up pregnant in the first place?" When the time came to give birth, they took me back and supported me through delivery. Even now, they occasionally insult me, but I endure it. Coming to terms with it all was difficult. I felt hopeless and as if I no longer belonged in this world. At one point, I even considered ending my life. (Adolescent mother, 18 years old, FGD, Gisagara District.)*

The analysis shows that anxiety is clearly influenced by pregnancy. With respect to the significant positive coefficients for mild and moderate anxiety, it can be said that adolescent mothers are more anxious than adolescent non-mothers. The OR associated with this coefficient is approximately 2.004, suggesting that, compared to adolescent non-mothers, adolescent mothers are about twice as likely to experience mild anxiety. Based on an OR of 4.170, adolescent mothers are also likely to experience more than four times the rate of moderate anxiety of adolescent non-mothers.

> *They experience deep trauma and intense anxiety, stemming from what has happened to them, how they feel treated by their family, and their perception of society's judgment. (Interview with a gender officer, Gisagara district.)*

Overall, adolescent pregnancies are significantly associated with experience of PTSD, moderate depression, and mild and moderate anxiety. The odds of experiencing PTSD, moderate depression, mild anxiety, and moderate anxiety are substantially higher for adolescent mothers than for adolescent non-mothers, indicating that pregnancy and birth have a pronounced negative impact on the mental health and wellbeing of adolescents.

4.5.2 Psychosocial effects associated with parents' response to adolescent pregnancy

The data reveal that parents' reactions have a profound influence on the mental health of adolescent mothers. It is essential to promote supportive family environments to mitigate this impact. The most frequent reactions of parents range from disappointment to outright anger. Tables 24, 25 and 26 show the degree to which such negative reactions exacerbate the psychological stress that adolescent mothers experience.

Table 24: Initial reactions of parents and relatives on learning of adolescent pregnancy

Reaction	Number	%
Supportive	148	25.21
Disappointed	257	43.78
Angry	418	71.21
Shocked	254	43.27
Expelled from home	90	15.33
Other	46	7.84

The data in Table 24 reveal in stark terms the negative responses of parents and the impact of cultural norms on family dynamics. The anger response reported by 71.21% of respondents stands out. This response indicates deep-seated cultural disapproval and potentially punitive attitudes to adolescent pregnancy, confirming that young women who fall pregnant are likely to be stigmatised by their immediate support networks and to experience considerable emotional distress. Such responses deepen the shame and guilt felt by adolescent mothers, and may have long-term psychological impacts.

15.33% of adolescent mothers were expelled from their home. This severe outcome underscores the harsh situation in which some pregnant adolescents find themselves, having to deal with the internal turmoil of an unexpected pregnancy and simultaneously separated from their primary support system. Being sent away can cause significant psychological stress and logistical challenges, including loss of family support, disruption of education, and exposure to poverty and health complications.

Although negative reactions dominate, 25.21% of adolescent mothers reported that their families had been supportive: this is a ray of hope. These examples show there is potential to change the attitudes of families and communities. If education is accompanied by a societal shift towards more supportive attitudes, it may be possible to increase the proportion of supportive families and improve outcomes for adolescent mothers and their children.

The three reactions - anger, expulsion, and support – partly describe how families perceive and manage adolescent pregnancy. They suggest that targeted interventions should aim to reduce stigma and help families adopt more supportive and constructive responses to adolescent pregnancy. Initiatives might include community and parental education programmes to improve understanding and reduce the punitive reactions that add so much to the psychosocial burdens adolescent mothers carry.

Table 25: Adolescent mothers' feelings about their parents and relatives' reactions

Feeling	Number	%
Supported	81	13.80
Judged	242	41.23
Guilty	219	37.31
Depressed	370	63.03
Anxious	314	53.49
Alone	170	28.96
Other	44	7.50

Adolescent mothers' feelings about the reactions of their parents and relatives are revealing. The mothers mainly describe negative emotions, further confirming the emotionally stressful situation in which many find themselves after they disclose their pregnancy.

The most striking response is the high percentage of adolescents who felt depressed. 63.03% of adolescent mothers reported this state of mind. The incidence of depression is probably due to the twin shocks of unexpected pregnancy and family disapproval or lack of support: it is a combination that can significantly affect the mental health of young mothers. The fact that over half of adolescent mothers also reported feeling anxious (53.49%) further confirms the intense emotional turmoil they experienced during this critical period. Anxiety may be driven by fear about the future, social stigma, and the practical stresses of entering motherhood at a young age.

A significant proportion of adolescent mothers felt judged (41.23%) and/or guilty (37.31%), reflecting the societal and familial expectations that are placed on young women. These feelings can arise if the adolescent mother internalises the criticisms of family members who believe that she has flouted social and behavioural norms. Adolescent mothers who feel judged are likely to feel both isolated and guilty, emotions that compound the psychological distress they already experience.

Between one quarter and one third of adolescent mothers (28.96%) reported that they felt alone. Their isolation can be emotional, if family support is withdrawn, and social, if peers distance themselves. The combination of judgment, guilt, and loneliness creates a formidable emotional burden that many adolescent mothers find difficult to carry, especially if they have limited resources to draw upon.

A smaller proportion of adolescent mothers (13.80%) felt supported by their parents or relatives. Such support can significantly mitigate the negative emotional pressures that are associated with adolescent pregnancy. Positive family support is evidently likely to promote better psychological outcomes for adolescent mothers.

This underlines the importance of promoting supportive familial networks to co-manage the challenges of adolescent pregnancy.

Overall, most adolescent mothers experienced negative feelings following their family's reaction to their pregnancy; many felt they were judged and experienced depression, anxiety, and guilt. These findings suggest that interventions should be available to support adolescent mothers emotionally but also educate families and assist them to be more understanding and supportive.

Table 26: Parental reactions and psychosocial outcomes for adolescent mothers (cross tabulation)

	Supported	Judged	Guilty	Depressed	Anxious	Alone	Total
No PTSD symptoms	66 (16.71)	173 (43.80)	146 (36.96)	239 (60.51)	209 (52.91)	109 (27.59)	395 (100)
PTSD symptoms	15 7.81)	69 (35.94)	73 (38.02)	131 (68.23)	105 (54.69)	61 (31.77)	192 (100)
Probably not depressed	67 (16.71)	175 (43.64)	150 (37.41)	240 (59.85)	216 (53.87)	117 (29.18)	401 (100)
Moderate depression	14 (7.91)	64 (36.16)	66 (37.29)	124 (70.06)	91 (51.41)	49 (27.68)	177 (100)
Severe depression	0	3 (33.33)	3 (33.33)	6 (66.67)	7 (77.78)	4 (44.44)	9 (100)
No anxiety	48 (21.43)	101 (45.09)	71 (31.70)	128 (57.14)	118 (52.68)	58 (25.89)	224 (100)
Mild anxiety	25 (10.20)	103 (42.04)	105 (42.86)	164 (66.94)	133 (54.29)	68 (27.76)	245 (100)
Moderate anxiety	8 (7.84)	37 (36.27)	37 (36.27)	65 (63.73)	54 (52.94)	39 (38.24)	102 (100)
Severe anxiety	0 (0.00)	1 (6.25)	6 (37.50)	13 (81.25)	9 (56.25)	5 (31.25)	16 (100)

The cross-tabulated analysis of psychosocial issues (PTSD, depression, and anxiety) associated with parental reactions shows how family dynamics affect the psychological wellbeing of adolescent mothers. For adolescent mothers, the analysis reveals that negative parental reactions to their pregnancy - and feelings of guilt and being judged - correlate strongly with adverse mental health outcomes such as PTSD, depression, and anxiety.

Mothers without PTSD symptoms reported relatively low perceived support from parents; only 16.71% felt supported, while a higher percentage felt judged (43.80%) or guilty (36.96%). This indicates that those without severe mental health issues also commonly perceived that they lacked parental support. This implies a general shortfall in positive family support. Family support nevertheless provides an essential buffer for young mothers, especially young mothers who experience mental health challenges.

Only 7.8% of adolescent mothers with relevant PTSD symptoms felt they were supported by their families, and a significantly higher proportion of adolescent mothers with PTSD symptoms felt judged (35.94%) or guilty (38.02%). Notably, a majority of these mothers also reported high levels of depression (68.23%) and anxiety (54.69%). These findings highlight that adverse parental reactions not only correlate with but may exacerbate the severity of PTSD symptoms. The data suggest that (perceived) parental judgment and adolescent guilt are both potent stressors that amplify the psychological distress of adolescent mothers.

This is even more the case for adolescent mothers who experience depression. A substantial proportion of adolescent mothers with moderate depression reported that they felt judged (36.16%) and/or guilty (37.29%) in response to their parents' reactions to their pregnancies. High incidences of depression (70.06%) and anxiety (51.41%) were also reported, stemming from their parents' negative responses. These associations suggest that moderate depression among adolescent mothers is significantly influenced by negative parental perceptions.

The situation escalated further in cases of severe depression. Adolescent mothers who reported high degrees of depression (66.67%) had a strikingly high level of anxiety (77.78%), alongside feelings of judgment and guilt. This indicates that severe depression is closely linked to more intense perceptions of parental criticism, confirming the impact of the family on the psychological health of adolescent mothers.

With respect to anxiety, as the anxiety of adolescent mothers in this sub group rose from mild to severe, their feelings of being judged and guilty rose correspondingly. Mothers with severe anxiety reported the highest levels of depression (81.25%) and feelings of isolation (31.25%), underscoring the connection between anxiety levels and parental criticism. Adolescent mothers must cope with the external pressures imposed by parents and relatives as well as the internal emotional shock of pregnancy.

Overall, the analysis underlines the influence of parental condemnation and support on the mental health outcomes of adolescent mothers. Criticism by parents is strongly associated with a range of mental health problems, from PTSD to severe anxiety and depression. These findings suggest that interventions are needed to enhance family support structures. By improving communication and understanding in families, it may be possible to mitigate some of the psychosocial challenges that adolescent mothers experience and enhance their mental health and quality of life.

4.5.3 Other psychosocial effects on adolescent mothers

The psychosocial effects discussed in the two preceding sub-sections draw mainly on quantitative data. Other complex challenges faced by adolescent mothers in Rwanda were discussed in FGDs and KIIs.

Mental health condition worsened by parental reactions to pregnancy

The psychological stress of adolescent mothers is magnified by cultural and societal norms that expect mothers to nurture and educate their daughters. The KII and FGD discussions revealed that, because mothers are expected culturally to guide their daughters through adolescence, they are often deeply disappointed by and sharply critical of their pregnant daughters,. For the same reason, when a pregnancy is disclosed, fathers frequently blame their wives for failing to adequately educate or control their daughter. Blame cascades down the family. This dynamic intensifies the psychological distress of young mothers, who feel intense guilt, anxiety and isolation because they are blamed for "bringing shame" upon the family.

> *Disputes with parents arising from unwanted pregnancies significantly impact the mental health of adolescent mothers. The latter often face conflicts at home and encounter persistent stigma associated with their situation, exacerbating their emotional and psychological distress. (The Director of Health and Social Development, Gasabo District.)*

> *The lack of acceptance by their families, coupled with insufficient timely intervention, can lead adolescent mothers to develop trauma. This trauma may escalate into severe mental health issues, including suicidal thoughts and attempts. (The Head of the Mental Health Unit, Nyagatare District Hospital.).*

> *As for me, my parents cannot take care of my child. When my child cries at night, they tell me to take that bastard outside so they can sleep. My parents tried to accept the situation, but whenever there is a problem they blame me, saying that I gave birth while I was still a teenager. This situation results in psychological distress, leading to self-blame and depression. (Adolescent mother, FGD, Musanze District.)*

My relationship with my siblings and parents has changed. Although it is not always extreme, there are times when they treat me as if I am a troublemaker. Previously, I could discuss my needs with them, but now I can no longer do so. My relationship with my aunt has also changed. I no longer feel affection for her, because she was the one who sent me to the boy I first slept with. I'm very angry with her, and she's aware of it. (Adolescent mother, FGD, Gisagara District.)

FGD and KII participants believed that supportive interventions are needed to address the needs of adolescent mothers but also their families. They suggested that such interventions should include specialised psychological services that help young mothers to cope and manage their stress, and family counselling to improve family communication skills and reduce stigmatising behaviour. These initiatives should become elements of a broader community-based mental health service that is sensitive to cultural and societal attitudes to adolescent pregnancy. By addressing these issues together, communities can better support adolescent mothers and mitigate the psychological harm they experience as a result of family and public criticism.

Stigma

The stigma associated with adolescent pregnancy remains a formidable barrier to social integration of adolescent mothers as well as their access to services. Adolescent mothers report that they are socially isolated and feel judged, which affects their self-esteem and also their ability to seek and receive medical and social support. In KIIs, community leaders and healthcare providers argued that community-driven initiatives are needed to educate the public and reduce the stigma that adolescent pregnancies attract. Such initiatives could include school-based programmes and community dialogues to promote the inclusion of young mothers.

It was hard for me to accept that I was pregnant, especially knowing my family wasn't happy with me. As soon as I told them, they gave me my own cooking pot, isolating me. At my age, having to care for myself and carry the child I hadn't planned was a huge burden. I felt as if my life had completely ended - grief and anger consumed me. (Adolescent mother, FGD, Gisagara District.)

Abortion and its effects

The stigma associated with adolescent pregnancy, alongside fear of social judgment, parents' criticisms, and stresses involved in having a child at a young age, drive many young women to consider or attempt abortions, often under unsafe conditions. In FGDs, a number of adolescent mothers revealed that they knew people who had arranged abortions, some of which were successful while others resulted in severe health complications. Some adolescent mothers described attempts to terminate their own pregnancy, which were unsuccessful and left them in distress and physical danger.

The Rwanda Investigation Bureau (RIB) needs to enhance its operational methods because it does not seriously follow up and detect perpetrators who evade imprisonment. For example, RIB was not helpful in our case because the man who raped her was extremely wealthy. He gave the girl money for an abortion, which led to severe complications and serious health problems. (Female key informant, Gasabo District.)

When I was pregnant, my father expelled me from home. In desperation, I attempted an abortion with a pill, but it failed. Eventually, I sought medical and psychological help at a hospital where I received counselling. (Adolescent mother, Nyagatare District.)

Pregnant adolescents often face significant social stigma, leading to feelings of isolation and inability to confide in peers and parents. This shaming can induce depression and trauma, pushing some to consider unsafe

methods of abortion, which tragically can result in severe health complications or even death. (Adolescent mother, FGD, Gisagara District.)

In KIIs, participants and particularly health professionals observed that unsafe abortion practices among adolescents frequently cause dangerous and sometimes fatal health conditions, including infections, severe bleeding, and long-term reproductive health problems. Some argued that more accessible, safe abortion services are needed as part of broader reproductive health provision. Participants also called for a comprehensive sexual education programme that will address the mechanics of reproduction but also educate young people about safe reproductive health options, including legal and safe pathways to abortion. This approach would mitigate the high risks associated with unsafe abortion practices, provide adolescent mothers with safer alternatives, and reduce the occurrence of severe health complications.

Suicide attempts

The psychosocial stress that accompanies adolescent pregnancy sometimes escalates to the point where young mothers consider or attempt suicide. During FGDs, some adolescent mothers courageously talked about their unsuccessful attempts to commit suicide and the lingering effects of those actions on their mental and physical health.

Being depressed and shamed affected me a lot, because of getting pregnant. Besides, seeing how my mother was heartbroken, and the way I always refused to listen to her advice, affected me emotionally. I spent so much time blaming myself for not listening to what my mother told me, and from there I started trying to commit suicide. I used rat poison, went to the Nyabugogo River, and wanted to go on the highest building in town and jump from the top floor. But all these attempts did not work. My brother was the one who made my relationship with my mum better again, and afterwards those bad thoughts of taking my life stopped until now. (Adolescent mother, 19 years old, Gasabo District.)

After finding out I was pregnant and being kicked out by my father, I felt like suicide was a way for me to escape the pain and suffering caused by my parents. (Adolescent mother, Nyagatare District.)

Living with my aunt in town led to a situation where I had unprotected sex during a one-night stand. At the time, I didn't know how to refuse and lacked knowledge about sexual and reproductive health. Now, I live with my mother in Jali Sector with my child and find temporary jobs to earn money for our living expenses and to care for my baby. This situation has taken a significant toll on my mental health. During my pregnancy, I felt extremely isolated, which led me to attempt suicide three times. (Adolescent mother, 18 years old, Gasabo District.)

Sure, I planned to have an abortion, but where would I have found the money to have an abortion? I had no money at all. I would stand at the hospital where my child was being treated, feeling that I could throw myself off and fall to the ground every time I went to see him. I felt like my life was over [after giving birth]. Every time I got there, I felt like jumping off. When I saw how my child was, I would think, "Can this little one really survive?" But when I went to church, they would stop me from despairing, saying, "Don't commit suicide. Your child will live and be healthy, and you don't know what he will become. Just stay here and take care of him. God will pay your bills." So I stayed. My mother went to ask a neighbour to lend her FRW 10,000 so I could pay for the medicine which had run out, and the doctor said if we didn't buy more, the child would die. We had already been charged FRW 60,000. They gave us medicine at the hospital and charged us, and then my mother told me, "The place I had reserved, I am going to use it because of you and let everyone take this as a lesson so that no one else will say I will pay money for them again". (Adolescent mother, FGD, Rubavu District.)

Such traumatic stories highlight the acute sense of hopelessness that can fill the lives of adolescent mothers, particularly when their situation is compounded by isolation, stigma, and the pressures of impending motherhood. Creating strong, community-based support networks and proactively monitoring at-risk individuals are two steps that can help to prevent tragic outcomes and ensure that adolescent mothers receive help when they are most vulnerable.

Prenatal and postnatal complications

Prenatal and postnatal complications are significant concerns for adolescent mothers, who may not receive adequate medical care during their pregnancy or after giving birth. Despite Rwanda's impressive antenatal record, some pregnant adolescents choose not to attend antenatal services because they are afraid of stigma or family criticism. This increases their vulnerability to complications, including eclampsia, anaemia, preterm labour, and infection.

Some adolescent mothers may require caesarean sections or other surgical procedures to ensure the safety of both the mother and the child. While these medical interventions are designed to protect health, they can sometimes lead to complications, such as infections or prolonged recovery periods. These physical challenges can also have significant psychosocial effects, including feelings of stress, frustration, or anxiety about their ability to care for their child or resume normal activities. Attending prenatal care appointments not only helps to reduce these risks but gives adolescent mothers psychosocial support and reassurance, enabling them to navigate such challenges more resiliently.

It is worth mentioning that medical risks are often exacerbated by the physiological immaturity of adolescent mothers, whose bodies are still developing. To mitigate such risks, the Rwandan healthcare system should strengthen its services and make them as accessible as possible to adolescent mothers.

Prostitution / sex work

The FDGs and KIIs revealed that adolescent pregnancy is sometimes associated with prostitution, particularly when young mothers face severe economic hardship and social isolation. Adolescent mothers reported that some were driven to sex work by the need to support themselves and their child. Their vulnerability is often compounded by lack of family support, social stigma, and the absence of employment opportunities for young mothers who lack qualifications.

> *We often have young children who have given birth at a young age, and they immediately turn to prostitution. Why? Because their families don't accept them, and being unaccepted by their families they lack a place to go. They end up seeking shelter, either staying with prostitutes nearby, or in a known prostitutes' area. So, this is one of the signs of mental illness: they are lost and seek refuge there. We have many such cases. When she abandons her child and leaves, that's not normal behaviour; no parent abandons her own child, no matter how young the parent was when she gave birth. No parent abandons her child. (The Director of Health and Social Development, Rubavu District.)*

Participants called for a comprehensive support system that includes vocational training, educational opportunities, and financial aid, to provide adolescent mothers with viable alternatives to prostitution. Additionally, they argued that social reintegration programmes are necessary because it is crucial to restore young mothers' relationships with their families and communities. Such programmes should aim to rebuild the social fabric and provide a supportive environment in which young women do not need to resort to prostitution to survive.

School dropout

During FGDs and KIIs, participants observed that pregnancy during adolescence frequently disrupts a young woman's education, resulting in her premature exit from school. It emerged that, in all five of the study's five districts, the majority of adolescent mothers who were attending school when they became pregnant ultimately dropped out. Some KII participants substantiated this point.

> *Dropping out of school is a problem because our country is losing a large number of young girls who get to stop studying, yet they could have been the ones to become future leaders. (The Director of Health and Social Development, Gasabo District.)*

> *My daughter's love for school flipped after getting pregnant and giving birth. She is no longer into sitting down and studying or doing homework, as she feels that being a mother does not fit with going back to being a student in primary school. (Female parent, FGD, Gasabo District.)*

Interruption of schooling not only affects immediate learning opportunities but has far-reaching socioeconomic implications. It limits a mother's future employment prospects and can perpetuate cycles of poverty. Rwanda's dropout rate highlights a critical issue: though education policies have progressed and encourage inclusive learning environments, the practical challenges and societal pressures associated with pregnancy and childbirth remain overwhelming for many young mothers.

Additionally, the FGDs revealed that some adolescent mothers face obstacles when they try to resume schooling after childbirth. They are often criticised by other students because they have a baby. Their families may not support them. If they cannot find someone to help take care of their baby, it is almost impossible to manage school and motherhood. And, because many mothers need to work to support their child, they may be forced to prioritise their employment over school.

To address the many effects of adolescent pregnancy requires a comprehensive and holistic approach that emphasises educational continuity, family reconciliation, and economic support for young mothers. Enhanced support systems and more flexible educational structures are necessary to integrate and retain adolescent mothers in the education system, secure their futures and those of their babies, and benefit society at large. A coordinated effort involving healthcare providers, judicial officers, educators, community leaders, and families is essential to create an environment in which adolescent mothers can be healthy, empowered, and socially integrated. By implementing targeted strategies that tackle the educational, psychological, and socio-economic barriers that adolescent mothers face, Rwanda can significantly improve the wellbeing and future prospects of one of its most vulnerable populations.

Economic vulnerability

The challenges faced by adolescent mothers extend far beyond the immediate consequences of pregnancy and childbirth. They have important socioeconomic vulnerabilities. The discussions in FGDs and KIIs revealed that the majority of adolescent mothers come from poor families and generally possess low levels of education, factors that severely restrict their chances of obtaining decent employment. Furthermore, poor relationships with parents and relatives often leave young mothers without support, unable to seek even casual jobs for subsistence, compounding their economic hardship.

Overall, addressing the multifaceted challenges faced by adolescent mothers requires a coordinated approach that involves multiple sectors, including health, education, social services, and civil society organisations. Only a comprehensive support network can effectively respond to the needs of adolescent mothers in Rwanda: it would help to reduce the dropout rates of adolescent mothers and improve their economic opportunities,

would promote an environment in which young mothers can thrive in spite of challenges, and would ultimately contribute to the broader social and economic stability of the community.

4.5.4 The psychosocial consequences of pregnancy on the families of adolescent mothers

This section examines the psychosocial effects of pregnancy on the families of adolescent mothers. It draws on qualitative data from focus group discussions and key informant interviews to assess changes in family relationships and in the support that families provide to adolescent mothers. The analysis also explores the emotional and material support that parents provide during pregnancy and how family reactions to adolescent pregnancy impact the mental and emotional wellbeing of adolescent mothers. Overall, the section sheds light on the challenges that families face and the need for comprehensive support systems.

4.5.4.1 Effects of parental support or lack of support during pregnancy

Parents' emotional support to adolescent mothers during pregnancy

Table 27: Did parents provide emotional support to adolescent mothers during pregnancy?

Response	Number	%
No	228	38.84
Yes	359	61.16
Total	587	100.00

61.16% of adolescent mothers reported that they had received emotional support from their parents, indicating that the majority had access to a nurturing environment crucial for their mental and emotional wellbeing during pregnancy. This support is likely to have included encouragement, empathy, and guidance, which will have helped the young women to cope with the challenges of pregnancy and early motherhood.

However, a substantial 38.84% of adolescent mothers reported that they had not received emotional support from their parents. This can have severe implications, as it may lead to increased stress, feelings of isolation, and mental health issues such as anxiety and depression. The absence of social and family support at such a critical period can affect the ability of young mothers to care for themselves and their children, affecting their overall health and development.

That 38.84% of adolescent mothers did not receive emotional support may reflect more than a gap in family support systems. When parents fail to support their children, it signals that families, and particularly parents, are themselves affected psychologically and emotionally by the shock of pregnancy. Their stress, disappointment or disapproval can significantly affect parents' ability to support their daughter emotionally. They too are likely to be grappling with feelings of shock or denial, shame or guilt.

> *I was deeply distressed because I had a child with a disability, who wasn't well mentally. My daughter was the one who helped care for him, to the point that I had taken her out of school so she could assist with him. We immediately told her, "Go and find the person who got you pregnant in Kigali". It felt like an incredibly difficult situation for us. (Mother of an adolescent mother, FGD, Gisagara District.)*

Finding out that my daughter was pregnant filled me with intense worry. I lost sleep, felt deep sadness as I wondered how I would return to caring for an infant, raising two children in the poverty I'm in. I only calmed down once I saw my grand-daughter gradually grow up. (Mother of an adolescent mother, FGD, Gisagara District.)

The emotional turmoil experienced by parents can lead to withdrawal or distancing behaviours. Providing support becomes difficult, and affects the overall family dynamics. This creates a vicious cycle in which the psychological shock felt by parents makes them unable to support their daughter, which in turn adds to her psychological stress.

Holistic interventions are needed that support adolescent mothers but also meet the emotional and psychological needs of parents. Programmes that teach parents about adolescent development, pregnancy, and the importance of emotional support can help to break this cycle and create a more supportive and understanding family environment for adolescent mothers.

Parental financial and material support to adolescent mothers during pregnancy

Table 28: Did parents provide financial or material support to adolescent mothers during pregnancy?

Response	Number	%
No	214	36.46
Yes	373	63.54
Total	587	100.00

The financial and material help that parents provide adolescent mothers during their pregnancy makes a crucial contribution to the wellbeing of adolescent mothers. According to the data, 63.54% of adolescent mothers reported that they had received financial or material support from parents during their pregnancy. FGD participants suggested that this support included essential items, such as maternity clothes, food, medical care, and possibly transport to prenatal centres. These gifts support the health and wellbeing of both the mother and her child.

However, 36.46% of adolescent mothers indicated that they did not receive any financial or material support from their parents. Such lack of support significantly adds to the strain on adolescent mothers, because the costs associated with pregnancy are substantial. Without financial assistance, adolescent mothers are likely to struggle to meet basic prenatal care requirements, potentially compromising their health and that of their baby. The absence of material support could also increase their stress and anxiety, exacerbating the challenges they face.

Failure to provide support may also reflect family poverty. The FGDs and KIIs revealed that many, and probably the majority of families of adolescent mothers were already economically stressed. The additional burdens of pregnancy stretched their resources even more. This suggests that external support systems and social safety nets should be in place to fill gaps in economic capacity.

As described above, parents may fail to provide financial and material support because they are not coping with the psychological and emotional shock of the pregnancy. A family in emotional turmoil and shock may be unable to organise material support.

These insights underscore the importance of comprehensive support strategies that address both the material and emotional needs of adolescent mothers and their families. Strategies should include financial aid, access to healthcare, and psychological support to ensure that families can provide a supportive environment for adolescent mothers throughout their pregnancy.

4.5.5 The effects of pregnancy on relationships with parents and relatives

Table 29: The relationship of adolescent mothers with parents and relatives after the pregnancy was announced

Status	Number	%
Improved	50	8.71
Stayed the same	187	32.58
Worsened	337	58.71
Total	574	100.00

This question revealed a concerning deterioration of family relationships. 58.71% of adolescent mothers (337 young women) reported that their relationships with their parents or relatives had worsened after they announced their pregnancy. This substantial figure highlights the capacity of adolescent pregnancy to generate conflict, disappointment, and social stress within the family, further increasing the emotional distress and isolation of adolescent mothers.

About one third of adolescent mothers (32.58%, 187 women) reported that their relationships with their parents or relatives stayed the same after they announced their pregnancy. This steadiness suggests that the relationships in some families were sufficiently robust to withstand the news in a stable manner. These families may possess strong communication skills or may support their members consistently.

Only a small fraction of adolescent mothers (8.71%, 50 young women) said that their relationships with parents or relatives improved after they announced their pregnancy. Improvement suggests that, in these cases, families came closer together to support the adolescent mother, perhaps turning the pregnancy into a shared purpose that strengthened family bonds.

These findings highlight the need for supportive interventions that will address negative outcomes that currently are common. Such programmes might enhance family communication, provide emotional and practical support, and educate parents about the needs of their pregnant daughters. Support of these kinds could help to reverse worsening relationships, stabilise family relationships, and improve the overall wellbeing of adolescent mothers and their children.

Overall, family reactions to adolescent pregnancy suggest that support systems should aim to cultivate a more understanding and supportive environment for adolescent mothers, addressing a range of family dynamics.

The effects of birth (delivery) on relationships with parents and relatives

Table 30: The relationship of adolescent mothers with parents and relatives after delivery

Status	Number	%
Improved	160	27.78
Stayed the same	229	39.76
Worsened	187	32.47
Total	576	100.00

The responses on this subject were mixed and have significant implications for the social systems that support adolescent mothers.

First, more than a quarter of adolescent mothers (27.78%, 160 young women) reported that their relationships with parents and relatives improved after the birth of their child. This might be because the birth of children often brings families together. Births generate a feeling of unity and shared purpose that causes family members to rally round to support the mother and newborn. The arrival of a new family member can shift perspectives and open a path to empathy and forgiveness.

In contrast, nearly a third of adolescent mothers (32.47%, 187 young women) said that their relationships with parents and relatives had worsened after delivery. This deterioration could be due to the increased pressures and demands that the new child placed on both the mother and her family. The responsibilities of childcare can intensify existing tensions, especially if the pregnancy was initially met with disapproval or if the family's resources are overstretched. Societal stigma or parental disappointment or anger could further strain family relationships.

The largest group of adolescent mothers (39.76%, 229 young women) reported that their relationships with parents or relatives stayed the same after delivery. This suggests that the initial reactions of many families to the pregnancy set the pattern of later interactions. Whether the reactions were supportive, strained, or neutral, the arrival of the child did not appear to alter the family's relationships.

These insights highlight that robust support systems need to be in place that can adapt to the evolving needs of adolescent mothers, and particularly help to mediate and improve strained family relationships. Interventions might include family counselling, community support programmes, and educational initiatives that promote understanding and reduce the stigma associated with adolescent pregnancy. All of these could help to stabilise families and improve family relationships.

4.5.5.1 Other effects on adolescent mothers' families

The effects of adolescent pregnancy on the families of young mothers are profound and varied. They influence every aspect of family dynamics. Nor are they only immediate; they can have long-lasting repercussions on a family's structure and the mental and emotional wellbeing of its members. The main negative effects include emotional distress and psychological disorders; inter-spouse and marital conflicts; conflicts between adolescent mothers and their parents or relatives; and community censure and stigma.

Emotional distress and psychological disorders

The unexpected news of an adolescent pregnancy often sends shockwaves through the family, resulting in significant psychological distress. Discussions in FGDs and KIIs revealed that some family members, particularly parents, experience feelings of shame, guilt, and failure, and question their effectiveness as parents. The stigma associated with adolescent pregnancy can amplify these feelings, leading to chronic stress and, in some cases, long-term psychological disorders such as depression and anxiety.

> *When I first learned that she was pregnant, I was very distressed, I felt deep sorrow, and I lost sleep, because I have a child with a disability who is not well mentally. My daughter was the one who helped take care of her, to the extent that I had pulled her out of school to help me with this child. We immediately told her, 'Go and find the one who did this to you in Kigali.' We really felt it was a very difficult situation. (Mother of an adolescent mother, FGD, Gisagara District.)*

> *When I found out, I spent two weeks in the house, constantly crying, overwhelmed with sadness. The problem is, as you know, nowadays if you punish a child for a mistake, they immediately report you and you can get prosecuted. (Female parent, FGD, Nyagatare District.)*

> *I was really emotionally devastated, and it couldn't be avoided. You feel like you've brought a catastrophe upon yourself, and I felt like it was a disaster that had befallen me. I felt like I was going mad. I felt ashamed, I cried, and I wondered how it was that in a family where all the girls were married off properly, it was my daughter who ended up pregnant. It overwhelmed me. The grief almost killed me, but it was my husband who calmed me down. He immediately went to the police, and the RIB came to look for the person who had abused our daughter, and now he is in jail. Another distressing thing is thinking that no other man will want her for marriage, the gossip about your daughter being pregnant, her future prospects, and more. (Mother of an adolescent mother, FGD, Gisagara District.)*

This issue highlights the importance of making psychological support available to pregnant adolescents but also to family members.

Inter-spouse and marital conflicts

The FGDs and KIIs revealed that adolescent pregnancy is sometimes a catalyst for marital discord, often bringing to the surface underlying tensions in the parents' relationship. Participants said that parents, generally the father, often blame their partner for failing to provide adequate supervision or moral guidance. This step often triggers mutual recrimination and blame. In the words of an opinion leader: "In our community, adolescent pregnancies often lead to familial conflicts, with husbands commonly placing blame on their wives" (Opinion leader, FGD, Musanze District).

> *The conflicts arose in my family, as she was the only that I have who got an unwanted pregnancy. She was very innocent, with good manners, and accepting it for me was not easy. I was blaming my wife for not monitoring her, but those disputes were between me and my wife only. I have never stopped providing what I have during and after her pregnancy. (Father of an adolescent mother, FGD, Gasabo District.)*

Blame is often rooted in the traditional expectation that mothers are primarily responsible for their daughters' upbringing and sexual education. When a pregnancy occurs, some assume that the mother has failed to properly guide and protect her daughter. Such accusations often lead to severe marital conflicts, undermining the cohesion and stability of the family.

This finding suggests that couples who find themselves in conflict should be encouraged to attend counselling sessions, to assist them to provide united support to their daughter.

Conflicts between adolescent mothers and their parents and relatives

Both FGDs and KIIs were almost unanimous in saying that some parents react with anger and disappointment to news that their adolescent daughter is pregnant, leaving pregnant adolescents feeling judged and unsupported. Intense conflicts can result that may profoundly disrupt family stability. These situations are emotionally volatile, making it difficult for parents and adolescents to communicate effectively without outside help.

> *Sometimes, parents respond harshly to their children's situations, resorting to insults and even expelling them from the home. This drastic action often pushes the young people into risky behaviours such as prostitution, as they seek ways to financially support themselves and their children. (Female opinion leader, FGD, Nyagatare District.)*

Such conflicts not only compound the vulnerability of adolescent mothers but place them in environments where they are at risk of sexual exploitation and other forms of harm.

> *I saw her loneliness and knew what she was going through before getting pregnant. She had a big group of friends. But once they knew about her pregnancy, none of them talked to or visited her again. She was depressed, and I am thankful that I was always there for her, because of how she was being neglected and ignored by her friends and family members as well. Moreover, her biological mother chased her away from home, and that's when I took the decision to take care of her. (Female guardian, FGD, Gasabo District.)*

During the FGMs and KIIs, participants argued that mediation and family therapy offer effective tools for repairing family relationships, by focusing on communication, understanding, and forgiveness.

Community censure and stigma

The broader community's reaction to adolescent pregnancy may also affect families. Participants in FGDs and KIIs said that stigma affects adolescent mothers but also their families, who may have to deal with the censure of their community and social isolation. Families may respond by withdrawing socially or becoming aggressive, further isolating them. Participants underscored the importance of community-based programmes that educate the public about adolescent pregnancy and promote more supportive and less judgmental attitudes.

These concerns highlights the need for comprehensive forms of support that address the needs of the families of adolescent mothers and integrate educational, psychological, economic, and social policy approaches with the aim of enabling families to cope through a period of unusual vulnerability.

4.6 Adolescent mothers' awareness of and use of psychosocial support systems, and their effectiveness

This section explores how aware adolescent mothers and non-mothers are of psychosocial support programmes, how they use them, and how effectively they meet adolescent mothers' needs. By identifying key sources of support and examining patterns of use, the research team was able to highlight gaps and suggest strategies to improve programmes' reach and impact, with the aim of advancing the wellbeing and social integration of adolescent mothers.

4.6.1 Awareness of psychosocial support systems

People cannot use psychosocial support systems if they are not aware that they exist. Building awareness is therefore essential, particularly in vulnerable populations, such as adolescent mothers and adolescents in general. Knowing what services are available and how to access them is a first step towards making use of the benefits they offer. Table 31 assesses the degree to which adolescent mothers and adolescent non-mothers are aware of the psychosocial support systems that are available in Rwanda.

Table 31: What psychosocial support systems do adolescent mothers and adolescent non-mothers know that they can turn to?

Source	Adolescent mothers	Adolescent non-mothers
A parent	117 (19.93)	176 (30.00)
A relative	43 (7.33)	44 (7.50)
A sibling	19 (3.24)	21 (3.60)
A friend or neighbour	78 (13.29)	77 (13.10)
The father of my baby	1 (0.17)	1 (0.20)
A leader or staff of a church	6 (1.02)	
A prayer group	27 (4.60)	21 (3.60)
A private psychotherapist	12 (2.04)	
A community healing space (sociotherapy, multifamily…)	5 (0.85)	5 (0.90)
A local health centre	277 (47.19)	295 (50.30)
A local hospital	160 (27.26)	147 (25.00)
A local government authority	41 (6.98)	58 (9.90)
Staff of a local NGO	8 (1.36)	2 (0.30)
Inshuti z'umuryango ("Friends of the family")	19 (3.24)	
Community health worker	95 (16.18)	
Media	1 (0.17)	3 (0.50)
Don't know any	35 (5.96)	43 (7.30)
Traditional healers	3 (0.51)	7 (1.20)
Others	12 (2.04)	12 (2.00)
None	34 (5.79)	13 (2.20)

Analysis revealed which support systems are known by each group and where groups faced challenges in accessing them. A majority of both adolescent mothers (47.19%) and non-mothers (50.30%) named local health centres, and 27.26% of adolescent mothers and 25% of adolescent non-mothers also said that local hospitals were key sources of support. The combined awareness of these two institutions (74.45% for adolescent mothers and 75.30% for adolescent non-mothers) suggests that they are key sources of psychosocial support that play a vital role in community health. Their high level of recognition is likely to reflect the accessibility and visibility of these facilities in the community, and the trust that the public places in them.

This finding concurs with Kayiteshonga et al (2022), a study of the prevalence of mental disorders, associated co-morbidities, health care knowledge and service utilisation in Rwanda, which found that: "Among the general population, 61.7% were aware of where they could seek support for mental health. For the general population who knew where to find mental health support, healthcare facilities were the most common mental health service identified (90.1%), followed by community health workers (38.8%). Traditional and religious healers were also recognised as options for mental health services" (p. 7).

In terms of awareness, adolescent non-mothers showed slightly more overall awareness of local health centres than adolescent mothers. This could suggest that adolescent non-mothers, perhaps because they face fewer constraints (such as childcare responsibilities), interact more often with preventive health services or community health education programmes. Their higher level of education may also explain why they are more aware.

The data show that adolescent non-mothers (30%) are significantly more aware than adolescent mothers (19.93%) that parents can be a source of support. The gap may suggest that adolescent non-mothers enjoy stronger family ties or that their family relationships are less stressed; equally, it may be due to the strains that adolescent pregnancy puts on family relationships and parental support.

Neither group is very aware of specialised mental health services (private psychotherapists, community healing spaces, sociotherapy). This perhaps confirms that important financial, cultural and information barriers hinder access to and use of such services. The low scores nevertheless suggest that mental health outreach should focus on the needs of adolescent women, and particularly the needs of adolescent mothers.

Interestingly, adolescent non-mothers were more aware that local government authorities and community health workers can provide support. This may be because this group is more actively involved in community and government initiatives that do not specifically target maternal health. This in turn suggests that adolescent mothers may be somewhat isolated from, or overlooked by, community outreach initiatives. If so, this gap needs bridging to ensure that adolescent mothers have equitable access to support services.

A concerning proportion of both groups - nearly 6% of adolescent mothers and over 7% of adolescent non-mothers - could not name any sources of psychosocial support that were available to them. This response is alarming and underlines the importance of comprehensive mental health education and outreach programmes. Such programmes should increase the visibility and accessibility of mental health resources, challenge stigma, and provide effective support to adolescent mothers.

Overall, the differences in awareness between adolescent mothers and adolescent non-mothers show that adolescent mothers have less access and support than adolescent non-mothers but also suggest targets for intervention that could improve the mental health outcomes for both groups, and adolescent mothers in particular. Enhancing mental health literacy and ensuring that adolescent mothers are included in outreach efforts are crucial steps towards building a more supportive and responsive community environment for all young women facing psychological challenges.

4.6.2 Use of psychosocial support services

Understanding whether and how adolescent mothers and non-mother adolescents use psychosocial support systems is crucial for assessing the effectiveness of those services and identifying barriers to their use. This knowledge can inform the design of interventions that address specific needs and remove obstacles to access. Table 32 shows the proportion of adolescent mothers and adolescent non-mothers who used psychosocial services in the last 12 months.

Table 32: Have you used a psychosocial support service in the last 12 months?

	Adolescent mothers	Adolescent non-mothers
No	494 (84.16)	516 (87.90)
Yes	93 (15.84)	71 (12.10)
Total	587 (100.00)	587 (100.00)

A striking 84.16% of adolescent mothers and an even higher 87.90% of adolescent non-mothers reported that they had not used any psychosocial support service in the last twelve months. This result underscores the extent to which services are present but are unused. It appears that mental health services are widely underused in Rwanda. In their study, Kayiteshonga et al (2022) found that "[r]eported utilization of mental health services for the general population stands at 5.3%" (p. 7).

The 15.84% of adolescent mothers who sought support are a minority. Many reasons might explain the low engagement rates: they include lack of awareness, accessibility issues, stigma associated with seeking psychological help, and lack of tailored services that meet the unique needs of young mothers, as well as logistical barriers (transport, financial cost, inability to take time away from childcare).

Even fewer adolescent non-mothers (12.10%) used psychosocial services. This might be because non-mothers needed them less, or because they were less aware of their relevance to their personal circumstances. However, broader systemic issues might also be responsible, for example, poor outreach or poor dissemination of information about their availability or the benefits they offer all adolescents (in addition to adolescent mothers).

The differences in use between the two groups suggest areas in which interventions could have most effect. Mother-friendly support services that address specific challenges such as postpartum depression, isolation from peers, and parenting stress, could increase their use by adolescent mothers. Initiatives that focused on general mental health awareness and education and destigmatised the use of psychosocial services could attract both mothers and non-mothers.

Overall, the data indicate that targeted strategies are needed to increase the accessibility and appeal of psychosocial services to all adolescents, including adolescent mothers. Such strategies could include school-based mental health programmes and community outreach initiatives, and might integrate mental health services into general adolescent health programmes. By enhancing the visibility of support mechanisms and removing barriers to their use, medical professionals and government officials could enhance the mental health and wellbeing of all adolescent young women.

Table 33 outlines the service providers to whom adolescent mothers and adolescent non-mothers turned for support.

Table 33: Service providers to whom adolescents turned for support in the last 12 months

	Adolescent mothers	Adolescent non-mothers
A parent	13 (13.98)	35 (49.30)
A relative	7 (7.53)	8 (11.27)
A sibling	4 (4.30)	1 (1.41)
A friend or neighbour	13 (13.98)	17 (23.94)
The father of my baby	1 (1.08)	
The leader or staff of a church	1 (1.08)	2 (2.82)
A prayer group	2 (2.15)	1 (1.41)
A private psychotherapist	6 (6.45)	
Community healing space (sociotherapy, multifamily…)	1 (1.08)	1 (1.41)
A local health centre	23 (24.73)	11 (15.49)
A local hospital	13 (13.98)	3 (4.23)
A local government authority	7 (7.53)	4 (5.63)
The leader or staff of a local NGO	3 (3.23)	1 (1.41)
Inshuti z'umuryango "Friends of the family"	0 (0.00)	2 (2.82)
Community health worker	16 (17.20)	2 (2.82)
Traditional healers	1 (1.08)	1 (1.41)
Other	6 (6.45)	2 (2.82)

Table 33 reveals notable differences between adolescent mothers and adolescent non-mothers. For both groups, local health centres and community health workers were among the most frequently accessed sources of support. These findings suggest that these services are among the most accessible, or possibly most affordable, sources of mental and emotional support.

If the figures for local health centres and hospitals are combined, 38.71% of adolescent mothers and 19.72% of adolescent non-mothers used services provided by these facilities. This probably indicates that adolescents relied heavily on formal healthcare structures to meet their health needs (including those associated with pregnancy and postnatal care). The lower use by adolescent non-mothers may indicate that they needed health care less often, that they were less aware of these services, or had less need of them to meet their general health needs.

Family members and friends were important sources of support for both adolescent mothers and adolescent non-mothers, but in different ways. Parents were very important for adolescent non-mothers (49.30%), and less so for adolescent mothers (13.98%), suggesting that non-mothers may rely more on parental support in general, possibly because they have fewer responsibilities or because their parents were also more available. Adolescent non-mothers also turned more often to friends and neighbours (23.94%) than adolescent mothers (13.98%), perhaps indicating that adolescent mothers are more isolated or that their time is largely consumed by childcare.

Adolescent mothers (17.20%) made far more use of community health workers than adolescent non-mothers (2.82%), possibly showing that they regularly need community-based health services for health monitoring

and advice. Neither group turned for support to religious or community groups, suggesting that these are not primary sources of psychosocial support for adolescent women.

Neither group consulted professional psychological services either: only 6.45% of adolescent mothers and no adolescent non-mothers did so. This suggests that cost, stigma, or lack of awareness deter adolescent women, or that they are unaware of the benefits that professional psychological services can offer. For further analysis of this issue, see Table 34.

This analysis indicates that there is a need for raise adolescent awareness of and improve their access to psychosocial services. They could particularly help adolescent mothers who face mental health challenges. Steps that might be taken include enhancement of community-based support, full integration of mental health services in the services provided by local health centres, and action to destigmatise professional psychological care.

Table 34: Reasons for not making use of psychosocial support services

Reasons	Adolescent mothers	Adolescent non-mothers
Did not feel any need of psychosocial support	404 (81.78)	466 (90.31)
Fear of stigma (for unplanned pregnancy)	30 (6.07)	8 (1.55)
Fear of stigma (for mental ill-health)	11 (2.23)	16 (3.10)
Cost / affordability	12 (2.43)	3 (0.58)
Distance to the support service in question	1 (0.20)	1 (0.19)
Did not know who to turn to	45 (9.11)	43 (8.33)
Was not aware that services were available	43 (8.70)	
Other	12 (2.43)	

Table 34 throws light on some of the barriers and perceptions that deter adolescents from seeking psychosocial support. On this matter, the most pronounced difference between the two groups was that adolescent non-mothers felt less need of psychosocial support. 90.31% of adolescent non-mothers felt they did not need psychosocial support, compared to 81.78% of adolescent mothers. This could indicate that adolescent non-mothers experience fewer psychosocial stressors or are less aware of psychosocial symptoms that require attention. It could also be that adolescents minimise their mental health needs for cultural reasons.

Stigma is an important deterrent. Predictably, more adolescent mothers (6.07%) than adolescent non-mothers (1.55%) said they were deterred from seeking psychosocial help. Many adolescent mothers indicated that they were afraid they would be criticised for being pregnant. Social condemnation can isolate adolescent mothers and prevent them from seeking support they need, harming their mental health. A similar number of adolescents in both groups said that they were deterred from seeking psychosocial help because they were afraid they would be stigmatised for being mentally ill. This stigma is a serious but more general problem that affects all adolescents regardless of motherhood status.

Affordability is a lesser barrier. It affected adolescent mothers (2.43%) slightly more than adolescent non-mothers (0.58%). This may indicate that adolescent mothers face additional financial burdens. Geographical access is also a minor barrier. The distance of support services deterred almost the same number of adolescents in each group. Though not a primary deterrent, it affects a segment of adolescents.

A significant proportion of adolescent mothers (9.11%) and adolescent non-mothers (8.33%) reported that

they did not know where to go for help, suggesting that information about psychosocial resources is not well disseminated. In addition, 8.70% of adolescent mothers said specifically that they were not aware of the services available to them, underlining that more needs to be done to make support options visible.

This finding is supported by Kayiteshonga et al (2022, p. 7). Discussing the "Reasons for not utilizing mental health services among participants who met the criteria for one or more mental disorders", the authors found that "the most common reason given for not seeking mental health support was that the individual did not know that mental health is a problem that required medical treatment (40.5%; n=722). Other reasons given for not seeking support were lack of money (39.6%; n=277), unable to get to location of services (32.5%; n=117) and fear of being stigmatized (27.1%; n=108)."

Overall, this analysis confirms that it is important to address both the perceived and practical barriers that prevent adolescents from accessing psychosocial support. Interventions should aim to reduce stigma through community education, enhance the affordability and physical accessibility of services, and disseminate information about support that is available. These steps will increase adolescent use of psychosocial services, improve their psychological health, and support the positive development of all adolescents.

4.6.3 How well do psychosocial support systems meet the needs of adolescent mothers?

It is vital to understand how well psychosocial support services meet the specific needs of adolescent mothers. Evaluations of effectiveness identify gaps in provision and interventions that will improve adolescents' psychological and emotional wellbeing. Tables 35 and 36 list the services that adolescent mothers and adolescent non-mothers received, and the degree to which both groups were satisfied.

Table 35: Psychosocial services that adolescent mothers and non-mothers accessed in the last 12 months

Service	Adolescent mothers	Adolescent non-mothers
Medicines	15 (16.13)	8 (11.30)
Psychological counselling	77 (82.80)	60 (84.50)
Referral to a more relevant provider	13 (13.98)	4 (5.60)
Material support	14 (15.05)	14 (19.70)
Legal support	3 (3.23)	
Other	5 (5.38)	8 (11.30)

The responses on this question reveal distinct patterns of support in each group.

Psychological counselling. This was the service that both groups accessed most frequently. 82.80% of adolescent mothers and 84.50% of the adolescent non-mothers who sought psychosocial services received counselling. The high percentages reflect the prevalence of mental health needs in both groups. Given the challenges associated with adolescence and motherhood, it is encouraging to see that psychological counselling is rather widely available.

Medicines. A modest portion of adolescent women obtained medicines (16.13% of adolescent mothers and 11.30% of adolescent non-mothers). The difference may be due to the specific health needs of mothers (during

pregnancy and after birth). Adolescent non-mothers are likely to have fewer health needs requiring medication. The gap is not large, however, which may suggest that some medicines were prescribed for conditions such as depression or anxiety.

Material support. Fewer adolescent mothers (15.05%) than adolescent non-mothers (19.70%) received material support, though the gap is not large. Material support is likely to have included food, clothing, and school supplies. Adolescent mothers probably received equipment and goods for childcare, whereas non-mothers will have received more help to meet educational or personal needs, particularly if they come from economically disadvantaged backgrounds.

Referrals. More adolescent mothers (13.98%) were referred to specialised or more relevant providers than non-mothers (5.60%). The difference may be due to the more complex needs of adolescent mothers, some of whom will have required specialised maternal health care, or legal support.

Legal support. A small number of the adolescent mothers who sought psychosocial services (3.23%) accessed legal support. No adolescent non-mothers reported doing so. This figure may not capture the extent of legal assistance accessed by adolescent mothers. The question focused on psychosocial support, and some adolescent mothers are likely to have sought legal advice directly from the Rwanda Investigation Bureau (RIB), specialised NGOs, or lawyers. These figures therefore probably understate the legal assistance accessed and needed by adolescent mothers.

Overall, this analysis shows that Rwanda offers robust psychological support to both adolescent mothers and adolescent non-mothers; but there are gaps in legal support for adolescent mothers, who may also not receive enough material support tailored to their needs. The data suggest a more holistic approach to service provision should be adopted, which would include psychological and medical support but also comprehensive legal and material aid, particularly for adolescent mothers who face more complex challenges. To fully protect the rights and wellbeing of adolescent mothers, further steps should be taken to make them aware of the legal services that are available to them, and make such services accessible.

Table 36: Satisfaction with the services received

	Adolescent mothers		Adolescent non-mothers	
Level of satisfaction	Number	%	Number	%
Very satisfied	50	53.76	45	63.38
Somewhat satisfied	37	39.78	21	29.58
Somewhat dissatisfied	2	2.15	2	2.82
Very dissatisfied	4	4.30	3	4.23
Total	93	100.00	71	100.00

The majority of adolescent mothers and adolescent non-mothers who responded reported high levels of satisfaction with the services they received. 53.76% of adolescent mothers and 63.38% of adolescent non-mothers said that they were very satisfied. This indicates that the services provided were generally effective. Adolescent non-mothers may have given a higher score because the services they received were more aligned with their needs or because their needs were less complex than those of adolescent mothers.

39.78% of adolescent mothers reported that they were only somewhat satisfied with the services they received, compared to 29.58% of non-mothers. The difference probably indicates that, while adolescent mothers benefited, their more complex needs were not fully met. There is potential to enhance service provision to meet their specific needs.

Taking the dissatisfied and very dissatisfied categories together, a small but significant number of adolescents in both groups reported discontent with the services provided. The number of dissatisfied adolescent mothers (6.45%) was slightly lower than the number of dissatisfied adolescent non-mothers (7.05%). Although low, these scores underscore the importance of improving the quality and effectiveness of services for all adolescent women.

The reasons for dissatisfaction are based on a small number of respondents and are not generalisable. They are nevertheless worth noting. Among dissatisfied adolescent mothers, some reported unhappiness with stigmatisation during treatment or the cost of services, as well as concerns about confidentiality and unresolved healing issues. Dissatisfied adolescent non-mothers primarily expressed dissatisfaction with stigmatisation; specifically, they reported that they had been received rudely or dismissively at service points. These responses, while limited in number, suggest that actions to address stigma, guarantee confidentiality, and make services more financially accessible would create a more supportive environment for adolescent women.

Overall, while levels of satisfaction were predominantly positive, evaluations of the effectiveness of the psychosocial support system must take into account the significant percentage of adolescent mothers and non-mothers who do not seek out or make use of these services. Steps should be taken to extend and enhance the outreach of services to adolescent women, both to make services more accessible to adolescent women, and to make adolescent women more aware of the benefits they can provide.

A SWOT analysis of preventive and support systems

Interpeace organised a SWOT workshop on 26 July 2024 at the Sainte Famille Hotel in Kigali. It brought together a variety of stakeholders, including government representatives and CSOs, to discuss how systems and mechanisms could prevent adolescent pregnancy and support adolescent mothers in Rwanda. By identifying strengths, weaknesses, opportunities, and threats (SWOT) in current preventive and support frameworks, the participants set out to understand how progress might be made on this critical issue. Through open dialogue and collaboration, the workshop aimed to develop actionable strategies that would enhance prevention initiatives and provide holistic support for adolescent mothers, ultimately contributing to the wellbeing of young people and their families throughout the country.

Current preventive systems and mechanisms

The systems that currently prevent adolescent pregnancy and support adolescent mothers in Rwanda include but are not limited to:

Regular community awareness/outreach. This mechanism uses a range of media channels to educate communities about adolescent pregnancy, reproductive health, and available support services.

Umugoroba w'imiryango. This traditional evening gathering promotes family discussions of social issues, including adolescent health, parenting, and responsibilities.

Health clubs in schools. These clubs create a safe environment in which adolescents can learn about health, sexuality, and personal development and promote healthy behaviours.

Peer-to-peer support. Adolescents support each through shared experiences and challenges. They learn resilience and collective coping strategies.

Coordination mechanisms. These national to local mechanisms ensure that different actors (government,

NGOs, community leaders) work together effectively to address adolescent pregnancy.

Education system. The education curriculum includes a sexual and reproductive health education package.

Policies, laws, and guidelines. These include a law and policy against gender-based violence, a national plan on family planning and adolescent sexual and reproductive health (FP/ASRH), and other legal frameworks designed to protect adolescents and prevent gender-based violence.

Youth corners and youth centres. These provide safe spaces for adolescents to engage in recreational and educational activities. They disseminate information and provide access to support services.

Table 37: SWOT analysis of prevention systems and mechanisms

Strengths	Weaknesses
Political will and country commitment. The Rwandan government strongly supports initiatives that address adolescent pregnancy, and promotes a favourable environment for programme implementation. **Policy literacy.** Adolescents and communities better understand the laws and policies that protect their rights and promote their health. **Awareness.** Effective campaigns have heightened awareness of adolescent health issues, leading to proactive community engagement. **Reporting mechanisms are accessible.** Multiple channels are available to report incidents of abuse and seek help, enhancing the safety of adolescents. **Sexual and reproductive health education.** SRH education is integrated across the competency-based curriculum, notably in social studies, biology, health sciences, communication skills, and Kinyarwanda, ensuring that age-appropriate discussions take place in a range of contexts. The curriculum takes a holistic approach and has eight cross-cutting themes, including sexual education, gender, and peace education.	**Poor dissemination of laws.** Laws are in place, but service providers and the public are not familiar with them, reducing their effectiveness. **Attitudes of some service providers.** Some adolescents are discouraged from seeking help they need by the stigma attached to early pregnancy and mental ill health, and the attitudes of some health and legal service providers. **Scarcity of service providers.** Not enough trained professionals are available in essential services, especially in rural areas. **Legal barriers.** Certain laws inadvertently restrict access to reproductive health services, particularly for minors. **Many teachers lack training.** This is particularly true of gender-responsive pedagogy and sexual reproductive health. The size of the teaching workforce (over 100,000) makes simultaneous training challenging, leading to inconsistent implementation of policies and curricula, and gaps in learning.
Opportunities	**Threats**
Political will and country commitment. Continued government support makes it possible to introduce new initiatives to prevent adolescent pregnancies. **New laws.** There are opportunities to create a more comprehensive legal framework to address the needs of adolescents. **Availability of institutions.** Many organisations are in a position to improve the provision of comprehensive support. **Strong coordination mechanisms.** Stakeholders communicate well and are ready to collaborate to improve resource allocation and service delivery.	**Cultural norms.** Traditional attitudes to gender and adolescent sexuality can hinder discussion and perpetuate stigmatisation of adolescent pregnancy. **Religious beliefs.** Certain beliefs discourage discussion of sexual health, undermining efforts to educate and provide support. **Geographical barriers.** Adolescents who live in remote locations cannot access all health services and support networks. **Poverty.** Economic hardship increases the incidence of adolescent pregnancy.

This SWOT analysis throws light on the effectiveness of efforts to prevent adolescent pregnancy in Rwanda. On the strength side, increased **policy literacy** and successful **awareness campaigns** have led to a more informed community, encouraging proactive engagement in health issues. The accessibility of reporting mechanisms enhances safety for adolescents, while the government's political commitment creates a positive environment for programme implementation. However, weaknesses such as **poor dissemination of laws**, the bias of some service providers, a **scarcity of trained professionals**, and legal barriers, limit the effectiveness of these initiatives. Opportunities arise from the positive political environment, the potential to develop new laws tailored to adolescents' needs, and the readiness of many institutions to collaborate. Conversely, threats include some **cultural norms** and religious beliefs, negative parenting styles, geographical barriers, and poverty: these significantly hinder open discussion of sexual health and access to services.

In a nutshell, the SWOT workshop highlighted the value of programmes and policies that prevent adolescent pregnancy in Rwanda. The workshop identified significant strengths and opportunities, but weaknesses and threats must be addressed to improve the overall effectiveness of efforts to prevent adolescent pregnancy and support adolescent mothers.

Analysis of available support systems

Current support systems for pregnant adolescents and adolescent mothers in Rwanda include psychosocial, medical, legal, and economic services.

The Isange One Stop Centre. This centre provides integrated support services for survivors of GBV, including legal, medical, and psychosocial assistance.

Health centres and district hospitals. These offer medical care and reproductive health services adapted to the needs of adolescents.

Community health workers. Health workers are vital links between healthcare systems and communities. They provide education and outreach.

An inclusive educational system. Rwanda's education policies allow pregnant adolescents to return to school. The aim is to promote educational attainment and reduce stigma.

The inclusive "Zero Out of School Children" project. This project, sponsored by MINEDUC, identifies and re-enrols children who do not currently attend school. Youth volunteers conduct door-to-door outreach to locate these children and assess their needs.

Contributing CSOs. Civil society organisations provide legal, psychosocial, educational and economic support, filling gaps in services.

A favourable legal and policy framework. Government policies create a supportive environment for adolescent mothers and protect their rights.

Social reintegration programmes. Initiatives by MIGEPROF assist adolescent mothers to rejoin their families and communities.

MIGEPROF financial support. Financial assistance programmes have been implemented to help adolescent mothers meet their needs.

MAJ services / access to justice bureaux. These offer legal services and guidance at district level to ensure that adolescents know their rights.

GBV offenders' registry. This programme helps to monitor and manage offenders, to protect adolescents.

Comprehensive sexual education. Programmes educate adolescents about reproductive health and responsible decision-making.

Empower Rwanda's holistic approach to supporting adolescent mothers

Empower Rwanda is a women-led NGO which was founded in Rwanda in 2019 to empower women and youth by providing skills, knowledge, and resources that will promote sustainable change for them, their families, and their communities. Currently, the organisation offers a wide range of essential support and educational programmes to over 400 teenage mothers in three districts of Eastern Province (Rwamagana, Gatsibo and Nyagatare).

The organisation addresses adolescent pregnancy from a holistic perspective, combining educational, emotional, social, and economic support. Through the Go Back to School Campaign, it promotes educational continuity by encouraging young mothers to resume formal schooling. Recognising the challenges these girls face, Empower Rwanda collaborates with families and communities to promote a supportive environment. It facilitates dialogues for family reintegration and educates parents on the importance of their daughters' education. For those unable to return to their families, Empower Rwanda provides access to Technical and Vocational Education and Training (TVET) programmes, which offer skill certifications that meet national standards. Early childhood development (ECD) centres provide safe childcare, enabling young mothers to attend school or training without the added worry of childcare responsibilities, while literacy and numeracy programmes prepare them for day-to-day life and future endeavours.

Empower Rwanda's empowerment programmes focus on the mental, physical, and social wellbeing of adolescent mothers. They emphasise informed decision-making and self-advocacy. Through its Sexual and Reproductive Health and Rights (SRHR) programme, adolescent mothers receive comprehensive education on family planning, self-care, and reproductive health, and get access to resources for accessing postnatal and prenatal care without fear of judgment. A scorecard system encourages young mothers to identify and raise the challenges they face, enabling them to advocate for improvements in healthcare and community support systems. The programme also includes psychosocial support to help adolescent mothers navigate the stigma often associated with teenage pregnancy. It provides counselling to boost their self-esteem and resilience.

Economic empowerment and long-term stability are central to Empower Rwanda's mission. Adolescent mothers are equipped with job-ready skills through TVET programmes and are supported in their journey toward economic independence by business startup assistance and employment guidance. Empower Rwanda's ECD centres ensure that young mothers can focus on skill development without worrying about childcare. The organisation's holistic approach acknowledges that sustainable empowerment requires more than just skills training; emotional resilience, family support, and social acceptance are integral. By combining psychosocial support with practical skills, Empower Rwanda creates a nurturing pathway for adolescent mothers to rebuild their lives, contribute to their communities, and achieve economic self-sufficiency.

Empower Rwanda's intervention model exemplifies, to a large extent, what a comprehensive support system for adolescent mothers should look like. Its multi-faceted approach addresses educational, emotional, legal and economic needs in a coherent manner. The organisation's holistic framework illustrates how inter-

ventions for adolescent mothers should be as comprehensive as possible and coordinated to ensure that young women receive an integrated package that effectively meets their complex needs and supports their long-term wellbeing and independence.

Table 38: SWOT analysis of support systems and mechanisms

Strengths	Weaknesses
Political will. The government is committed to addressing adolescent pregnancy, through policies and resource allocation. It encourages adolescent mothers to return to school after delivery. It ensures that they are not expelled and that schools address stigma.	**Limited funds**: Financial constraints restrict the ability of the government and other bodies to provide comprehensive support to adolescent mothers. **Prosecutions.** The judicial system is unable to bring criminal charges against offenders promptly, while social institutions are unable to provide ongoing financial support to adolescent mothers who have experienced abuse. **Sexual education (CSE).** The education system is unable to provide comprehensive sexual education to youths who are not in school, limiting their access to essential information. **Follow-up for adolescent mothers. Adolescents received at Isange One Stop Centre or at health centres for psychosocial support cannot be followed up.** This limits the long-term effectiveness of the assistance provided. **Temporary youth corners.** These are not consistently available or accessible, leading to gaps in support. **Schooling after childbirth.** Not all adolescent mothers are able to resume their schooling after they have given birth. **Support to adolescent mothers.** H**olistic and coordinated support is not available to adolescent mothers. As a result, services are** fragmented and do not adequately address all the needs of adolescent mothers.
Opportunities	**Threats**
Holistic services. The Isange One Stop Centre offers a model for comprehensive support that can be expanded. **Toll-free assistance**. This phone service provides immediate help and encourages reporting of abuse.	**Cultural and social attitudes.** Deep-rooted stigmatisation of adolescent pregnancy deters open communication and support. Social condemnation discourages adolescents from seeking help and increases their feelings of shame and isolation. **Delayed reporting of cases**. Fear of stigma and retribution often delay reporting of abuse, hindering timely action. **Victim blaming.** Social attitudes perpetuate stigma, harming the mental health and self-esteem of adolescents. **Religious beliefs.** Some religious doctrines oppose discussion of reproductive health, complicating education and support. **Poor awareness of child rights.** Many adolescents and families lack knowledge of child rights and the support that adolescent mothers can obtain, impeding their access to services.

The SWOT analysis of support systems throws light on the effectiveness of the services that adolescent mothers in Rwanda can access. A notable strength is the political will of the Rwandan government, which is committed to addressing adolescent pregnancy through robust policies and resource allocation. However, limited funds restrict the capacity to provide comprehensive support services for teen mothers, and many adolescents and families lack awareness of their rights, which can impede their access to essential services.

Social attitudes, marked by negative mind-sets and victim blaming, often discourage adolescents from seeking help, contributing to the culture of silence that surrounds adolescent pregnancy. This problem is compounded

by disparate reporting mechanisms for criminal and civil cases that leave adolescent mothers vulnerable and without essential support.

Holistic services are offered by the Isange One Stop Centre, which provides a model comprehensive support network. The toll-free line for assistance offers immediate help and allows victims to report abuse. However, cultural barriers and religious beliefs continue to hinder open discussions of reproductive health, and fear of stigma can delay reporting of cases, obstructing timely interventions and support for adolescents.

Overall, the support systems currently in place reflect a concerted effort to address the complex challenges that adolescent mothers in Rwanda face. The system has significant strengths and opportunities, but persistent weaknesses and threats must be acknowledged and addressed.

Actors that finance or deliver services should take steps to enhance awareness of child rights, combat stigma, and improve the availability of resources. These steps will create a more supportive environment for adolescent mothers. Through collaboration and by expanding access to services, Rwanda can empower adolescents and improve their wellbeing, promote their healthy development, and reduce the incidence of adolescent pregnancy.

In conclusion, the SWOT analysis indicates that systems to prevent adolescent pregnancy and support adolescent mothers should adopt a comprehensive approach to tackle the complex challenges that adolescent mothers face. Strong government commitment and integrated support services are assets, but limited funding and social stigma hinder their effectiveness.

Additionally, cultural norms and religious beliefs pose threats to open dialogue and deter adolescents from using essential services. To enhance the impact of measures to prevent adolescent pregnancy and measures to support adolescent mothers, it will be crucial to leverage opportunities for collaboration and resource mobilisation. By fostering partnerships among stakeholders and addressing identified weaknesses, Rwanda can create a more supportive environment for adolescents, ultimately reducing the incidence of adolescent pregnancies and ensuring that young mothers receive the support they need to thrive.

5. GENERAL CONCLUSION AND RECOMMENDATIONS

This research on adolescent pregnancy in Rwanda has examined factors and effects that influence the lives of adolescent mothers and their families, and highlighted significant public health concerns and socio-economic disparities. Using quantitative and qualitative data, the study has identified several areas where focused interventions can effectively support adolescent mothers and their broader family networks.

The study names factors that particularly contribute to adolescent pregnancy: insufficient sexual and reproductive health knowledge; inconsistent contraceptive use; some parenting styles; peer pressure; economic vulnerabilities; and insufficient male involvement in pregnancy prevention. Coercive sexual encounters and the influence of digital media amplify risks. To address them, comprehensive educational programmes, enhanced legal protection, and robust digital literacy initiatives are required.

The psychosocial effects on adolescent mothers are profound. Increases in PTSD, depression, and anxiety are primarily due to adverse family responses and social stigmatisation of unplanned pregnancy. The consequences for adolescent mothers are often severe: they include expulsion from home, exclusion, unsafe abortion, mental ill-health, and disrupted education. To address these challenges, a holistic approach is required.

The impact on the families of adolescent mothers is also significant. The unexpected news of an adolescent's pregnancy often sends shockwaves through the family, resulting in psychological distress and sometimes long-term depression and anxiety. Marital discord and strained parental relationships further complicate family relationships. Interventions need to include family counselling and community support to restore harmony and stability.

A critical area highlighted by the research is the gap between awareness of and actual use of psychosocial support systems. Although most adolescent women are aware of the services provided by local health centres, alarmingly few adolescent women actually make use of them. They are deterred by stigmatisation of early pregnancy, cost, logistical challenges, and the fact that services often do not address the specific needs of adolescent mothers and their families.

The study calls for a comprehensive, multi-sectoral response from the health, education, legal, social service and economic sectors. These public services need to create a supportive environment that fulfils the complex needs of adolescent mothers. Action should be taken to enhance adolescents' knowledge of sexual and reproductive health, multiply accessible and youth-friendly contraceptive services, transform parenting practices, and strengthen economic support systems. Specialised mental health services should address the specific needs of adolescent mothers, and include action to combat the stigma and isolation they frequently experience.

In conclusion, adopting a holistic strategy that combines immediate health care with broader socio-economic and educational support will significantly improve the life prospects and wellbeing of adolescent mothers. The strategy should meet the needs of adolescent mothers but also create a more supportive and understanding community, and thereby promote Rwanda's ongoing efforts to achieve equity and empower young women.

Towards a holistic approach for preventing adolescent pregnancies and supporting adolescent mothers in Rwanda

Adolescent pregnancies pose significant challenges, not only to the health and well-being of young mothers but also to their families and communities. A comprehensive and holistic approach is essential to address the root causes and far-reaching consequences of this issue. Drawing on the findings from the study, the comprehensive model proposed will address the issue of adolescent pregnancy by focusing on two interlinked components: prevention interventions and support interventions. It will tackle the root causes of adolescent pregnancy while providing targeted, holistic support to adolescent mothers and their families. The model incorporates psychological, social, legal, and economic dimensions and recommends interventions tailored to meet the needs of younger and older adolescents, as well as their families. It also integrates inter-sectoral coordination and rigorous monitoring and evaluation, to ensure that solutions for adolescent pregnancy are comprehensive.

1. Prevention interventions

- **Psychological and educational empowerment**. Prevention starts by equipping younger adolescents with foundational sexual and reproductive health (SRH) education and resilience skills. Schools, communities, and families work together to provide gender-responsive pedagogy, and address knowledge gaps on reproductive health. Psychological interventions strengthen adolescents' decision-making skills and confidence, helping them to resist peer pressure and risky behaviours.

- **Family and community engagement**. Families and communities play a pivotal role in prevention. Programmes focus on creating spaces for parent-child dialogue on SRH topics and promote positive parenting practices. Campaigns target men and male adolescents with the aim of fostering positive masculinity and shared responsibility for pregnancy prevention. Community-based initiatives strengthen parental supervision while addressing problems caused by economic struggles or intrafamily conflicts.

- **Legal protections and advocacy**. Strengthened legal frameworks ensure that adolescents are protected from exploitation and abuse. To promote accountability, laws are enforced against child defilement, reporting mechanisms are simplified, and the reach of Isange One Stop Centres is extended. Awareness campaigns educate families and adolescents about their rights and the legal protections that are available, ensuring comprehensive support for at-risk populations.

- **Economic interventions**. To address economic vulnerabilities, pro-poor programmes include scholarships for girls, vocational training, and financial literacy initiatives. These programmes reduce pressure on families to push adolescents into early marriage or transactional relationships. Strengthened social protection mechanisms for vulnerable households ensure that economic instability does not lead to early pregnancy.

2. Support interventions for adolescent mothers and their families

- **Mental health and emotional support**. Adolescent mothers and their families often face stigma, anxiety, and strained relationships. To reduce these stresses, psychosocial support programmes offer counselling for mothers and mediation services for families. Community-based mental health services that include follow-up support, address PTSD, depression, and other psychological challenges faced by young mothers.

- **Social reintegration and community inclusion**. To reduce stigma, awareness campaigns encourage

communities to accept and show empathy for adolescent mothers. Mentorship programmes pair adolescent mothers with experienced counsellors to support their reintegration in society. Intergenerational dialogue initiatives build trust between adolescent mothers and their families.

- **Health and educational access**. Healthcare services prioritise adolescent mothers for prenatal and postnatal care, reduce costs, and act to prevent stigmatisation. Flexible schooling programmes and Early Childhood Development (ECD) centres enable adolescent mothers to continue their education. Scholarships and mentorship programmes empower them to build better futures for themselves and their children.

- **Economic empowerment for families**. Vocational training, access to microfinance, and social protection programmes enable adolescent mothers to achieve economic independence. For families, economic empowerment initiatives include skills training and income-generating projects. These efforts reduce reliance on transactional relationships and other harmful coping mechanisms, and strengthen family resilience.

3. Inter-sectoral coordination

Successful implementation of this model relies on robust coordination of government institutions, CSOs, schools, healthcare providers, and community leaders.

- **Task force establishment.** A dedicated task force ensures cross-sector collaboration. It brings together key stakeholders, including MIGEPROF, MINEDUC, MoH and RBC, MINALOC, and relevant CSOs, to align efforts and avoid duplication.

- **Integrated services.** Local governments facilitate collaboration at community level. They integrate health, education, legal, and economic support services. For example, schools and health centres partner to provide SRH education and mental health counselling.

- **Harmonised policies.** Ministries and CSOs co-develop policies that align with national priorities and are responsive to community needs, to ensure that solutions are effective and sustainable.

4. Monitoring and evaluation (M&E)

A robust M&E framework is essential to ensure accountability, track progress, and measure the impact of interventions.

- **Outcome indicators.** Metrics include rates of adolescent pregnancy, mental health outcomes, school reintegration rates of adolescent mothers, and economic stability of their families.

- **Real-time data collection.** Regular data collection tools (such as surveys, focus groups, and administrative records) provide insights into programme effectiveness and areas requiring improvement.

- **Stakeholder feedback.** Continuous input from adolescent mothers, families, and community leaders ensure that interventions remain relevant and effective.

- **Performance reviews.** Regular reviews by the inter-sectoral task force assess the effectiveness of strategies, adapt interventions, and scale up successful initiatives.

- **Community-led audits.** Local committees evaluate progress and make recommendations to deci-

sion-makers. The committees include local leaders, CSOs, FBOs, community structures such as *Inshuti z'umuryango, Umugoroba w'imiryango, Abajyanama b'ubuzima*, and representatives of adolescents and their families,

Holistic integration of families

Recognising the pivotal role of families, the approach integrates family-focused strategies into prevention and support interventions. By addressing intrafamily conflicts, strengthening parent-child relationships, and providing economic support, it creates environments in which adolescent mothers can thrive.

This comprehensive model offers a tailored and inclusive approach that can lower the incidence of adolescent pregnancy and support adolescent mothers and their families. By combining preventive and supportive measures, and supporting them with inter-sectoral coordination and robust M&E, the model empowers adolescents, strengthens families, and builds resilient communities. By encouraging all stakeholders to collaborate, it opens a path to sustainable change and improved outcomes for Rwanda's youth. The model's preventive and support strategies are presented in Tables 39, 40 and 41. These set out the key issues, frame strategic recommendations, and identify the institutions that should lead efforts to address each challenge or gap.

Table 39: Strategies to prevent adolescent pregnancy

Dimension	Issue	Action	Responsible institutions
Health/education	Adolescents lack knowledge of sexual and reproductive health.	Fully implement comprehensive sexual and reproductive health education in schools, families, and communities.	MINEDUC, MoH, RBC, CSOs, local leaders.
Health	Contraception is not accessible, is not used, or is not understood.	Strengthen efforts to change social attitudes and norms that hinder sexual and reproductive health education.	Ministry of Health, RBC, CSOs, healthcare providers, FBOs.
		Campaign in favour of contraception. Provide free or subsidised contraceptives.	Ministry of Health, RBC, CSOs, healthcare providers.
Education	Teachers lack training in gender-responsive pedagogy and sexual reproductive health.	➔ **Implement a phased, continuous training programme** for teachers on gender-responsive pedagogy and sexual and reproductive health. ➔ Prioritise areas with the greatest need.	MINEDUC, REB.
		➔ **Establish a monitoring and support system** to ensure that schools consistently teach pupils about gender-responsiveness and sexual health. ➔ Offer teachers regular assessments and feedback loops.	MINEDUC and REB in collaboration with local district education offices.
Family	Parenting styles.	➔ Promote positive parenting techniques. Strengthen and extend positive parenting workshops. ➔ Promote positive masculinity and encourage men to reduce adolescent pregnancy rates.	MIGEPROF, CSOs, NCDA, MINIYOUTH.
Family/community	GBV responses focus on victims and overlook perpetrator accountability. Social stigma, financial dependence, and biased media reporting shield offenders and perpetuate victim-blaming.	➔ Prosecute men who commit GBV offences against adolescent women. ➔ Fully implement the sexual offender registry to deter GBV crimes and increase public accountability.	RIB, National Public Prosecution Authority (NPPA), Supreme Court.
		Enforce ethical media guidelines to eliminate victim-blaming and promote responsible GBV reporting.	MIGEPROF, Rwanda Media Commission, Rwanda Governance Board (RGB), National Commission for Human Rights (NCHR),
		Run family-level awareness campaigns to encourage people to report gender-based violence and reduce social tolerance of it.	MIGEPROF, RIB, and CSOs.

Dimension	Issue	Action	Responsible institutions
	Insufficient male involvement in adolescent pregnancy prevention.	➔ Deliver comprehensive sexual and reproductive health (SRH) education tailored specifically for men and male adolescents, focusing on promoting responsible behaviour, fostering positive masculinity, and encouraging their active role in preventing adolescent pregnancies. ➔ Enhance positive masculine behaviour and encourage men to act responsibly to reduce unintended pregnancies.	MIGEPROF, Ministry of Health, RBC, CSOs.
Family/community	Peer pressure.	Run community, family, and school-based programmes to teach adolescents about peer influence and sound decision-making.	Ministry of Youth, youth organisations, schools, CSOs, MIGEPROF, MINEDUC.
		Develop programmes that encourage families, schools, communities, churches and other social groups to discuss sexual and reproductive health.	Ministry of Youth, RBC, youth organisations, schools, CSOs, RGB.
	Parents do not supervise or talk to their children enough because they work very long hours.	➔ Encourage employers to allow parents to spend more time at home. ➔ Encourage the formation of community groups to advise and support parents. ➔ Encourage parents to stay at home with their children at least once a week, making time to eat and talk together. ➔ Encourage families to spend time and relax with other families.	Ministry of Public Service and Labor, MIGEPROF, businesses, NGOs.
	Intrafamily conflicts.	➔ Provide family counselling services to manage marital disputes and improve family relationships. ➔ Train community-based family counsellors to run family healing spaces.	MIGEPROF, MINALOC, NGOs, FBOs, local leaders, development partners.
	Economic hardship.	➔ Strengthen social protection programmes to improve the social and economic condition of families that face economic hardship. ➔ Mobilise additional resources; take steps to reach the most disadvantaged households; design interventions that enable families to graduate swiftly out of support programmes. ➔ Use the social registry to identify and target families that are most in need.	MINALOC, Ministry of Public Service and Labor, CSOs, financial institutions.
		➔ Reinforce programmes for young people that teach community-based skills and provide job training and financial literacy. ➔ Target girls and vulnerable communities. ➔ Provide start-up loans.	Ministry of Public Service and Labor, CSOs, financial institutions, MINALOC, MINECOFIN.

Dimension	Issue	Action	Responsible institutions
Legal	Forced sexual intercourse.	Raise community awareness of child defilement and rape. Make the public aware that both are criminal offences.	RIB, judiciary, CSOs.
		Prosecute individuals who commit crimes of child defilement, or forced sexual intercourse, as well as individuals who cover up such crimes.	RIB, National Public Prosecution Authority, judiciary, legal aid organisations.
Media/digital	Harmful influences of digital and social media.	➜ Conduct digital literacy campaigns; run digital literacy workshops in schools and for parents and the community with the aim of reducing risky behaviour. ➜ Monitor and remove harmful online content.	Ministry of ICT, schools, parents, telecommunications companies.
Cross-sector	Scattered and uncoordinated interventions.	Strengthen cross-sectoral collaboration between ministries, local leaders, and community organisations to ensure they adopt a unified approach to preventing adolescent pregnancy. ➜ Create a task force that brings together MIGEPROF, MINEDUC, MoH, Ministry of Justice, and MINALOC, alongside key CSOs and community organisations, to develop and monitor policies that prevent adolescent pregnancy and meet the needs of adolescent mothers. ➜ Establish monitoring and evaluation mechanisms to track the progress of efforts to reduce adolescent pregnancy and support adolescent mothers.	All relevant ministries, local leaders, CSOs.

Table 40: Strategies to mitigate the impact of adolescent pregnancy and early motherhood and resolve issues in support systems

Dimension	Issue	Action	Responsible institutions
Health	PTSD, depression, anxiety, suicide risk, and risky behaviours.	Design and provide a comprehensive mental health services package that specifically targets the needs of adolescent mothers. Decentralise mental health services to health centres.	Ministry of Health in collaboration with CSOs.
	Prenatal and postnatal health complications.	➔ Put in place a mechanism that gives adolescent mothers priority access to prenatal and postnatal care. ➔ Reduce and remove obstacles (such as cost and stigma) that impede adolescent mothers from accessing healthcare services they need. ➔ Waive the requirement that pregnant adolescents must attend prenatal and post-natal care with their partner.[1]	Ministry of Health.
	Unprofessional behaviour of medical staff.	Train healthcare providers to receive and treat adolescents in a manner that is supportive and non-discriminatory.	Ministry of Health, RBC, health care facilities.
		Implement a monitoring system to ensure that all health facilities comply with the above policy.	Ministry of Health, RBC, health care facilities.
Health (psycho-education, psychosocial support)	Abusive and stigmatising reactions of parents, relatives and society.	➔ Run community-based programmes to educate families about the impact on families of abusive and stigmatising behaviour. Include discussion of family responses to adolescent pregnancy. ➔ Offer mediation services to improve family relationships.	MIGEPROF, CSOs.
	Emotional distress as a result of family reactions.	Provide support groups and counselling to help the families of adolescent mothers to show understanding and give them support.	MOH(RBC) in collaboration with social services, CSOs, FBOs.
	Cultural stigmas and family condemnation.	Run national campaigns to reduce the stigma associated with adolescent pregnancy and promote inclusive community practices.	MIGEPROF, media outlets.
	Unsafe abortion.	➔ Increase access to reproductive health services, especially for adolescent women. ➔ Provide comprehensive education on sexual and reproductive health, including reproductive choices. ➔ Disseminate legal and sexual information on unsafe abortion and its risks.	MoH, Education Department, legal aid providers.

1 In Rwanda, pregnant women are required to attend pre- and postnatal visits at health centres with their partner. This requirement is particularly impractical for adolescents and cases where pregnancy is due to abuse. Some participants noted that the policy disproportionately impacts pregnant adolescents, who are less able to access essential healthcare.

Dimension	Issue	Action	Responsible institutions
Economic	Prostitution due to economic hardship and family rejection.	➔ Create vocational training, microfinance and other economic opportunities for adolescent mothers, to reduce their economic hardship and the risk that they may resort to prostitution to survive. ➔ Extend social protection programmes to vulnerable families.	MINALOC (LODA) and NCDA in collaboration with NGOs.
	Exclusion of adolescent mothers from services that can assist them.	Take steps to make it easier for adolescent mothers to access social protection programmes designed to help them.	NCDA, LODA.
Education (formal)	Educational disruption.	**Provide scholarships and financial support to adolescent mothers who want to continue or resume their education.**	MINEDUC, MIGEPROF, CSOs, FBOs and development partners.
		To assist young mothers to pursue their education, ***e*xpand early childhood development (ECD) services and their opening hours.**	MINEDUC, MIGEPROF and National Early Childhood Development Programme (NCDP).
		Develop a mentorship and support programme that pairs adolescent mothers with trained counsellors or peer mentors.	MIGEPROF, REB, CSOs, FBOs.
		Run community awareness campaigns to reduce the stigma associated with adolescent motherhood.	MIGEPROF, MINEDUC, Rwanda Broadcasting Agency (RBA), CSOs and FBOs.
Legal	Reluctance to report child abuse.	➔ Develop and enforce mechanisms that protect victims of child abuse. ➔ Reward reporting of abuse. Take steps to ensure that people can report abuse without fear of retribution or financial loss.	MIGEPROF and MINIJUST in collaboration with CSOs, legal aid institutions and justice organisations.
		Implement legal and rights educational programmes that inform adolescents and their families about their rights and the support available to them.	Ministry of Justice, RIB, CSOs specialising in children's and women's rights.
	Legal and bureaucratic barriers.	➔ Make legal and medical services more accessible to adolescents and adolescent mothers by extending the Isange One Stop Centres to local health centres. ➔ Simplify the legal process for reporting and addressing adolescent abuse cases. ➔ Ensure cases of defilement are prosecuted in a way that includes both criminal and civil actions as required by law.	Ministry of Justice, MoH, RBC, RIB.

Dimension	Issue	Action	Responsible institutions
Cross-sector	Scattered and uncoordinated interventions.	Strengthen cross-sectoral collaboration between ministries, local leaders, and community organisations to ensure they adopt a unified and comprehensive approach to supporting adolescent mothers. ➜ Create a task force that brings together MIGEPROF, MINEDUC, MoH, the Ministry of Justice, and MINALOC, alongside key NGOs and community organisations, to develop and monitor policies that prevent adolescent pregnancy and meet the needs of adolescent mothers. ➜ Establish monitoring and evaluation frameworks to track the progress of efforts to reduce adolescent pregnancy and improve support for adolescent mothers.	All relevant ministries, local leaders, NGOs.

Table 41: Strategies to mitigate the impact of adolescent pregnancies on young mothers' families

Dimension	Issue	Action	Responsible institutions
Health	Psychological distress caused by unexpected pregnancy.	➔ Make psychological support available to help families and adolescent mothers manage the initial shock of pregnancy and subsequent. Include counselling services and stress management workshops. ➔ Offer adolescent mothers substantive psychosocial support over a period (not just short term first aid).	Ministry of Health, RBC, community mental health services, NGOs.
Family/community	Marital discord triggered by pregnancy.	➔ Put family mediation and counselling programmes in place to address family conflicts, and enable parents to cooperate as they manage adolescent pregnancy. ➔ Create family healing spaces where family members can participate in healing and dialogue facilitated by trained community-based counsellors.	MIGEPROF, MINALOC, NGOs, local leaders.
Family/community	Strained parent-child relationships.	➔ Launch initiatives to teach parents positive parenting and supportive parenting practices. Run communication workshops to help families communicate and sustain healthy relationships during crises. ➔ Set up intergenerational family dialogue spaces that encourage positive communications between parents and their children.	Ministry of Education, NGOs, MIGEPROF.
	Community stigma and isolation.	➔ Promote community awareness programmes that address the stigma associated with adolescent pregnancy and promote inclusion. Focus on empathy and building community support. ➔ Disseminate and raise public awareness of gender-based violence and violence against children, and the importance of combating both, as well as supporting victim reintegration.	MIGEPROF, local leaders.
Cross-sector	Scattered and uncoordinated interventions.	➔ Strengthen cross-sector collaboration between ministries, local leaders, and community organisations to ensure that they adopt a unified approach to adolescent pregnancy and its impact on families.	All relevant ministries, local leaders, NGOs.

It is crucial to emphasise that interventions to prevent adolescent pregnancy and support adolescent mothers should adopt a holistic and age-specific approach that addresses the psychological, social, legal, and economic dimensions of this issue. Adolescents, in their formative years, require foundational education on reproductive health to build knowledge about their bodies and the risks associated with early sexual activity. Psychologically, they benefit from nurturing environments that build confidence and resilience to peer pressure. Socially, interventions should foster open communication with parents and peers.

For older adolescents, who are more equipped to face the realities of early motherhood, interventions must address more complex and layered challenges. Psychologically, they require mental health support to manage stress, anxiety, and stigma. Socially, it is important to combat isolation by encouraging their inclusion via mentorship programmes and community support systems. Legally, adolescents need protection against exploitation and early marriage. Interventions should enable them to advocate for their rights and secure access to justice. Economically, older adolescents need targeted vocational training, access to education, and economic opportunities to break cycles of poverty and ensure a stable future for themselves and their children.

By integrating these psychological, social, legal, and economic perspectives in interventions tailored to meet the needs of different age groups, programmes can holistically address the causes and consequences of adolescent pregnancy, and empower adolescents to make informed decisions and achieve sustainable wellbeing.

References

Adimora DE and Onwu AO (2019). Socio-demographic factors of early sexual debut and depression among adolescents. Afr Health Sci., 19(3):2634-2644. doi: 10.4314/ahs.v19i3.39. PMID: 32127836; PMCID: PMC7040293.

Agba AM, Mathias A, Blessing N (2022). Psychosocial Determinant of Teenage Pregnancy among Selected Secondary School Students in Akamkpa Local Government Area, Cross River State, Nigeria. *Global Journal of Pure and Applied Sciences,* Vol. 28: 51-62. https://dx.doi.org/10.4314/gjpas.v28i1.7.

Ajprodho Jijukirwa (2020). A situational analysis of teenage pregnancy and teen mothers in Rwanda.

Alukagberie ME, Elmusharaf K, Ibrahim N et al (2023). Factors associated with adolescent pregnancy and public health interventions to address in Nigeria: a scoping review. *Reprod Health* 20, 95. https://doi.org/10.1186/s12978-023-01629-5.

Aluga D and Okolie EA (2021). Socioeconomic determinants of teenage pregnancy and early motherhood in the United Kingdom: A perspective. *Health Promot Perspect. 11(4):426-429*. doi: 10.34172/hpp.2021.52. PMID: 35079585; PMCID: PMC8767081.

Amoadu, M, Ansah EW, Assopiah P et al (2022). Socio-cultural factors influencing adolescent pregnancy in Ghana: a scoping review. *BMC Pregnancy Childbirth* 22, 834. https://doi.org/10.1186/s12884-022-05172-2.

Bitew DA, Akalu Y, Belsti Y et al (2023). Predictors of underage pregnancy among women aged 15–19 in highly prevalent regions of Ethiopia: a multilevel analysis based on EDHS, 2016. *Sci Rep*, 13, 857. https://doi.org/10.1038/s41598-023-27805-y

Black C and DeBlassie RR (1985). Adolescent pregnancy: contributing factors, consequences, treatment, and plausible solutions. *Adolescence*, 20(78):281-90. PMID: 4050569.

Brahmbhatt H, Kågesten A, Emerson M, Decker MR, Olumide AO, Ojengbede O, Lou C, Sonenstein FL, Blum RW, Delany-Moretlwe S (2014). Prevalence and determinants of adolescent pregnancy in urban disadvantaged settings across five cities. *J Adolesc Health*, 55(6 Suppl):S48-57. doi: 10.1016/j.jadohealth.2014.07.023. Epub 2014 Nov 19. PMID: 25454003; PMCID: PMC4454788.

Dubik JD, Aniteye P, Solina R (2022). Socio-cultural factors influencing teenage pregnancy in the East Mamprusi Municipality, Ghana. *African Journal of Reproductive Health*, 26(5):1-11, 120-130. doi: 10.29063/ajrh2022/v26i5.13.

Dukunde. MJ and Niyizamwiyitira C (2023). Prediction of teenage pregnancy in Rwanda. *Journal of Emerging Technologies and Innovative Research (JETIR)*, Volume 10, Issue 1.

Ganchimeg T, Ota E, Morisaki N et al, on behalf of the WHO Multicountry Survey on Maternal Newborn Health Research Network (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study. *BJOG*, 121 (Suppl. 1): 40–48.

Girl Effect Rwanda (2020). Conversations with teen mothers. A qualitative study on Teen Pregnancies in Rwanda.

Hakizimana D, Logan J, Wong R (2019). Risk Factors for Pregnancies Among Females Age 15 to 19 in Rwanda: A Secondary Data Analysis of the 2014/2015 Rwanda Demographic and Health Survey (RDHS). *Journal of Management and Strategy*, Vol. 10, No. 2, Special Issue.

Kabera Bazubagira A and Umumararungu CK (2023). Predictors of teenagers' pregnancies in Rwanda: Evidence from selected Districts. *International Journal of Research in Business and Social Science*, 2147-4478, 12(3), 607–612. https://doi.org/10.20525/ijrbs.v12i3.2434.

Kagabika MB and Irabona W (2021). Causes and consequences of teenage pregnancy in Rwanda: Case of Kirehe District. *International Journal of Research*, Vol. 8, Issue 8.

Kayiteshonga Y, Sezibera V, Mugabo L. et al (2022). Prevalence of mental disorders, associated co-morbidities, health care knowledge and service utilization in Rwanda – towards a blueprint for promoting mental health care services in low- and middle-income countries? *BMC Public Health* **22**, 1858. https://doi.org/10.1186/s12889-022-14165-x.

Keddie MA (1992). Psychosocial factors associated with teenage pregnancy in Jamaica. *Adolescence*, 27(108):873-90.

Lamb ME and Garretson ME (2003). The effects of interviewer gender and child gender on the informativeness of alleged child sexual abuse victims in forensic interviews. *Law and Human Behavior, 27*(2), 157–171. https://doi.org/10.1023/A:1022595129689.

Ministère de l'administration locale, du développement et des affaires sociales (2004). Dénombrement des victimes du génocide, Rapport final. Version révisée. Kigali.

Ministry of Gender and Family Promotion (2021). The Revised National Gender Policy.

Ministry of Health (2024). The Rwanda National Children and Adolescent Mental Health Strategy 2024-2028.

Malunga G, Sangong S, Saah FI et al (2023). Prevalence and factors associated with adolescent pregnancies in Zambia: a systematic review from 2000–2022. *Arch Public Health*, 81, 27. https://doi.org/10.1186/s13690-023-01045-y.

National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH), and ICF International (2021). Rwanda Demographic and Health Survey 2019-20, Final Report.

Oke YF (2010). Poverty and Teenage Pregnancy: The Dynamics in Developing Countries. OIDA International Journal of Sustainable Development, Vol. 2, No. 5, pp. 63-66.

Pollner M (1998). The effects of interviewer gender in mental health interviews. *J Nerv Ment Dis.,* 186(6):369-73. doi: 10.1097/00005053-199806000-00008. PMID: 9653422.

Qolesa SK (2017). Factors Influencing Teenage Pregnancy in Heidedal Location, Mangaung District. Master's Degree Thesis, University of the Western Cape.

Republic of Rwanda (2017). National Strategy for Transformation (NST1).

Republic of Rwanda (2020). Rwanda's Vision 2050.

Senkyire EK, Boateng D, Boakye FO et al (2022). Socio-economic factors associated with adolescent

pregnancy and motherhood: Analysis of the 2017 Ghana maternal health survey. *PLoS One,* 17(12):e0272131. doi: 10.1371/journal.pone.0272131. PMID: 36584169; PMCID: PMC9803283.

Setia MS (2016). Methodology Series Module 2: Case-control Studies. *Indian J Dermatol*, 61(2):146-51. doi: 10.4103/0019-5154.177773. PMID: 27057012; PMCID: PMC4817437.

Umumararungu CK and Bazubagira AK (2023). Complexity of teen mothers and its implications on family wellbeing in Rwanda. *Research in Business & Social Science IJRBS*, Vol 12, No 4. ISSN: 2147-4478.

Vafai Y, Thoma ME, Steinberg JR (2020). Association Between First Depressive Episode in the Same Year as Sexual Debut and Teenage Pregnancy. *J Adolesc Health*, 67(2):239-244. doi: 10.1016/j.jadohealth.2020.02.001. Epub 2020 Apr 5. PMID: 32268997; PMCID: PMC7934530.

World Health Organization (WHO) (2018). WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience: Summary. Geneva, Switzerland. Licence: CC BY-NC-SA 3.0 IGO. At https://iris.who.int/bitstream/handle/10665/259947/WHO-RHR-18.02-eng.pdf.

Yakubu I and Salisu WJ (2018). Determinants of adolescent pregnancy in sub-Saharan Africa: a systematic review. *Reproductive Health*, 15:15, pp. 1-11. doi: 10.1186/s12978-018-0460-4.

Interpeace
INTERNATIONAL ORGANIZATION FOR PEACEBUILDING

Interpeace Kigali Office

Kimihurura KG 2 Ave, 15 Kigali, Rwanda.
(+25) 0784404884

Interpeace Headquarters

Office 5A, Avenue de France 23,
1202 Geneva, Switzerland

www.interpeace.org @InterpeaceTweet @interpeace

In Partnership with the United Nations