Policy Brief

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17-year-old adolescent mother who lives alone in Rwanda © Nathalie Bertrams/GAGE 2020

Adolescent pregnancy and sexual reproductive health and rights in Rwanda

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Introduction

Rwanda has seen an increase in reported rates of adolescent pregnancy from 4.1% in 2005 to 7.5%[2] in 2015 (Hakizimana et al., 2019). There has been growing consensus on the need to prioritise adolescents' sexual and reproductive health and rights (ASRHR) in order to improve girls' capability outcomes. Embedded in gender inequities and multidimensional poverty, unwanted pregnancy remains a major concern for adolescent girls in Rwanda (Walker et al., 2014).

Over the last decade, the Rwandan government has been credited for promoting gender equality and ASRHR (Coast et al., 2019; Isimbi et al., 2017). Recent laws and policies have prioritised access to ASRHR, broadened access to legal abortions and implemented a six-year strategy focused on ASRHR (MOH, 2018).

The Family Planning/Adolescent Sexual Reproductive Health & Rights strategy focuses on six components, recognising their interconnectedness (MOH, 2018):

- demand for family planning (FP) and ASRHR
- supply of quality services
- youth friendliness of services
- policy environment
- governance, data use and accountability
- innovation.

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2 It is noted that these percentages likely underestimate the true rates of pregnancy.

However, there are significant coverage gaps, exacerbating unmet need for ASRHR services and information (Isimbi et al., 2017; Abbott et al., 2014).

While there is a growing body of research on the experience of Rwandan youth (defined as 14–35 years), there is limited evidence focused on adolescents (aged 10–19 years) (Stavropoulou and Gupta-Archer, 2017), and specifically on younger adolescents (aged 10–14 years). This research aims to provide insights into adolescent pregnancy in Rwanda by analysing the drivers, patterns and impacts on adolescents of all ages, as well as to evaluate gaps in interventions that address ASRHR.

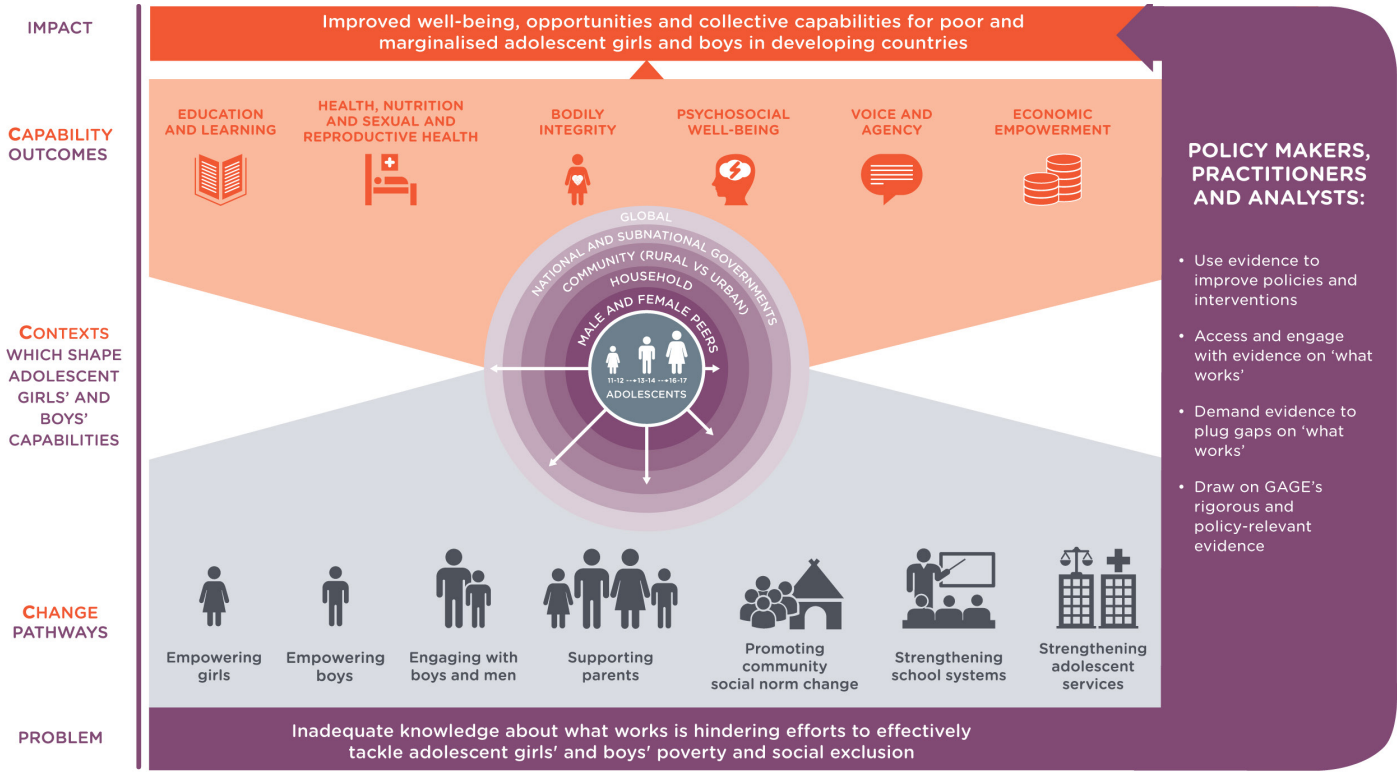
Methodology and conceptual framework

The GAGE conceptual framework demonstrates how to address the 'problem' of evidence gaps to support adolescent development and empowerment through three overarching dimensions: capability outcomes, contexts and change strategies (GAGE, 2019). Our research recognises that adolescents live in interconnected contexts, and require strategies that intervene at the individual, household and community level as well as strengthening systems at the state and global level (Coast et al., 2019). The compounding of these contexts, micro-level strategies and macro-level systems contributes to adolescents' capability outcomes.

To evaluate whether interventions successfully deliver services and achieve the intended GAGE capability outcomes, a framework adapted from five principles highlighted in Engel et al. (2019) has been used in this research. These principles underpin the effective delivery of a comprehensive approach to ASRHR:

- Equity in access requires that every adolescent be able to access high-quality information and a full range of services in a timely manner, and that interventions and delivery platforms be inclusive.
- Quality of care entails provision of accurate, respectful, non-judgemental and confidential ASRHR services and information tailored to adolescents' developmental stages.
- Accountability requires that adolescents can hold healthcare providers accountable to monitor quality of service provision and identify gaps.
- Multisectorality requires that interventions build synergies across sectors.
- Meaningful engagement requires that adolescents are included as equal and valuable partners in decision making with other stakeholders to increase utilisation of care, effectiveness and sustainability. This implies adolescent engagement in the design, implementation and monitoring of interventions (Caffe et al., 2017).

Figure 1: GAGE conceptual framework



Source: GAGE, 2019.

This framework is useful to evaluate interventions for adolescent pregnancy because of its holistic and rights-based framing. Given the emphasis in the GAGE conceptual framework on 'contexts', the fifth principle is modified to include meaningful engagement of parents and the community (Ahinkorah et al., 2019; Zulu et al., 2018). Intrinsic to these five principles is the need to respond to and design interventions that meet adolescents' unique attributes, needs and the barriers they face (Engel et al., 2019).

The study includes both primary and secondary research. Semi-structured interviews were conducted between January and April 2020. Key informants were purposively sampled from non-government-organisation and private-sector representatives, as well as independent researchers. After contacting 40 people via email, interviews were held with eight people, all of whom were based in Kigali. Interventions were mapped non-systematically, and relied on available, accessible information. Only those interventions were included that related to GAGE capability outcomes. This is likely to have omitted smaller-scale interventions not formally evaluated or reported on. These findings were further complemented by an analysis of academic and grey literature from academic, government and organisation sources.

Key findings

Drivers and patterns

Figure 1 employs the socio-ecological model within the GAGE conceptual framework to analyse the drivers of adolescent pregnancy. Since the drivers are interrelated, there is overlap between different levels of the model. Power dynamics play a key role in adolescent pregnancy and are involved in many levels of the model, including gender-inequitable perceptions, gender-based violence and transactional sex.

Adolescents

Poverty is a major driver of adolescent pregnancy – 11.1% of adolescents (aged 15–19) from the poorest households are reported to have begun childbearing, compared to 5.8% from the wealthiest households (NISR, 2016). It constrains adolescents' access to education, health services and their power over decision-making (Hakizimana et al., 2019). Girls from low-income households may have fewer options to avoid taking sexual risks to get economic support, including having sex with older men in transactional sexual relationships to pay for school or buy material goods (Test et al., 2012; Isimbi et al., 2017).

Disparities in education levels may increase girls' vulnerabilities to pregnancy. It is reported that 6.9% of adolescents (aged 15–19) with primary education have had a live birth, compared to 3.2% with secondary or higher education (NISR, 2016). School-based education can potentially delay marriage and pregnancy as it equips girls with information about ASRHR (Hakizimana et al., 2019). While adolescent girls may face interrupted education for various reasons, including but not limited to its financial inaccessibility and parent perceptions of the returns on education, informants reported that many drop out of school upon becoming pregnant. Further, dropping out of school

Figure 2: Socio-ecological model

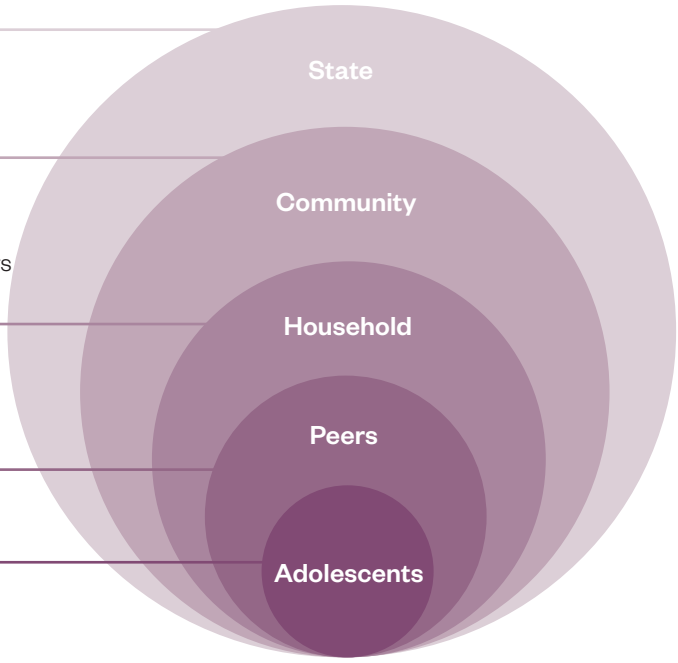
State
- Laws on legal abortion
- Laws on access to SRHR products

Community
- Religion
- Gendered sexual activity
- Availability of health services
- Transactional sex
- Knowledge and attitudes of education and health service providers
- Social attitudes towards marriage and childbearing

Household
- Intergenerational comunication
- Parental attitudes
- Household composition
- Early cohabitation

Peers
- Consensual sex
- Rape/sexual violence

Adolescents
- Economic status
- Level of education
- SRHR information and products



Source: Based on the GAGE conceptual framework in Figure 1 and expanded.

Adolescent girls in Rwanda © Nathatlie Bertrams/GAGE 2020

affects girls' capabilities, such as voice and agency, as it reduces access to employment opportunities and lowers self-confidence. Reflecting the stigma shown toward females who do not complete their education, an informant also stated that out-of-school adolescents experience greater discrimination from the police when reporting rape.

Adolescents' needs for ASRHR information and products are primarily unmet (Coast et al., 2019). Adolescents often struggle to access affordable contraceptives, especially emergency contraceptives (Abbott et al., 2014). Peers are an important source for ASRHR information; however, this often results in inaccurate and misleading information, leading to misconceptions about ASRHR (Coast et al., 2019; Pradhan et al., 2015).

Peers

Informants reported that adolescents were commonly in consensual relationships at the time of their first sexual experience. However, girls are embarrassed to negotiate or demand condom use. Moreover, boys are reluctant to use condoms out of fear that in the time it takes to put on a condom, girls could change their minds (Stavropoulou and Gupta-Archer, 2017). As an anonymous informant confirmed, *'condoms are there, it's just how confident people feel using them because of the stigma.'*

> Condoms are there, it's just how confident people feel using them because of the stigma.
>
> (Anonymous informant)

Sexual relationships that girls engage in often involve unequal power dynamics in terms of age, gender norms, economic inequality and their intersections. This may result in high levels of coercion and violence including rape, which adolescent girls report as a major concern surrounding their bodily integrity (Isimbi et al., 2017).

Household

Parents are often uncomfortable having open conversations about sex-related matters, resulting in adolescents having limited knowledge of ASRHR and services (Biddlecom et al., 2009). Parents' disapproval of sexual behaviour before marriage may increase adolescents' reluctance to seek help from healthcare centres that require parental consent (Basinga et al., 2012b). Additionally, respondents claimed that adolescents with single or no parents are perceived to be less disciplined and more exposed to early sexual debut due to the lack of financial support

and protection, compared to adolescents raised in dual-headed households.

While the minimum age for legal marriage in Rwanda is 21, early cohabitation remains common (Coast et al., 2019). Pregnant adolescents below 21 may choose to cohabit until they are able to register their marriage legally. Furthermore, parents may encourage a female adolescent to cohabit if she is pregnant to prevent or reduce the social and economic costs of an unwanted pregnancy. Parents may also choose to informally 'marry' their daughters off early to access the 'bride price' (a payment to the bride's family) and avoid paying an increased dowry (Stavropoulou and Gupta-Archer, 2017; UN Rwanda, n.d.).

Community

Adolescents are broadly impacted by the perceptions, norms, information and service provision of their communities. Gender norms leave girls especially stigmatised for being sexually active and prevent them from seeking contraception (Basinga et al., 2012a). Fear of judgement and stigma remains a consistent pattern in informants' responses detailing adolescents' avoidance of health facilities and reluctance to access services across Rwanda (Coast et al., 2019; Abbott et al., 2014).

Key informants discussed how many schools and health centres are founded and run by churches promoting abstinence until marriage, contributing to a resistance towards the implementation of comprehensive sexuality education and universal access to contraceptives.

Key informants also noted that teachers without specialised training often ignore ASRHR topics in the curriculum. Similarly, healthcare providers may refuse to offer contraceptives or services (Keogh et al., 2018; Sommer and Mmari, 2015) by exercising their right in accordance with the 'Professional Code of Ethics' to refuse to participate in activities that are counter to their personal moral and professional convictions (Påfs et al., 2020; Ministry of Health, 2009). This contradicts the Law Relating to Human Reproductive Health (2016) that mandates against any form of discrimination in access to consultation and healthcare services (Article 5, Article 18), to prevent the personal beliefs of healthcare providers from influencing the way they carry out their professional duties, leading to inequitable care.

Lastly, there are strong associations between marriage and childbearing, given the societal expectation that marriage should produce children, and both sexes face pressure to have a family (National Research Council, 1993). Adolescents who 'marry' (cohabit) are often unable to continue attending school and are required to 'prove' their fertility, which also increases their likelihood of experiencing intimate partner violence (UNICEF, 2005). This has pertinent implications for girls' capabilities, not only relating to bodily integrity and freedom from violence, but all other GAGE capability outcomes as well.

Government

All respondents stressed the limited accessibility of ASRHR products and services as a reason for adolescent pregnancy. This is particularly important as many informants stated that adolescents begin engaging in sexual activities from the age of 12. While the Ministry of Health has increased the provision of contraceptive services at the community level through trained community health workers, an unmet need for contraception persists. In accordance with the Law Establishing Medical Professional Liability Insurance (2013), adolescents under 18 require parental consent to access contraceptives or abortion services, as the majority age is interpreted to be 18 years old (Article 2) in the Law Relating to Reproductive Health (2016). This contradicts the right to access services related to human reproductive health (Article 8) and the obligation to provide necessary medicines or services to anyone in need (Article 17) as outlined in the Law Relating to Reproductive Health (2016).

Although emergency contraceptives (EC) are listed in Rwanda's Essential Drug List, barriers to access prohibit women from using ECs as a safe and effective way of preventing unwanted pregnancy after unprotected sex (Basinga et al., 2012b). These barriers include lack of knowledge and affordability and geographic inaccessibility, as ECs are only available for purchase at pharmacies and are not distributed at the community level (ICEC, 2015).

Recent amendments have legalised abortion in Rwanda under five conditions, comprising sexual assault, rape, forced marriage, incest and potential harm to the unborn child or the mother (Abbott et al., 2014). They must be performed by a Ministry of Health-certified medical doctor. According to the Rwanda Penal Code (2018), abortions performed outside of these legal exemptions are punished on the same grounds as a self-induced abortion (Article 125). A lack of awareness about these recent amendments among adolescents and healthcare providers (Påfs et al., 2020) continues to impede access to safe abortion.

Adolescents are required to have parental consent if seeking abortion services, which respondents highlighted makes girls fearful and reluctant to access safe abortions. Limited abortion access leads women to seek unsafe abortions to terminate their pregnancies (Guttmacher, 2013), which can result in morbidity and mortality. Påfs et al. (2020) find that some healthcare providers have negative social attitudes towards abortion services. While they claim that they do not have the skills to perform the service, they are simply unwilling to offer an abortion. Moreover, Sibomana et al. (2013) find that some Rwandan women

> I don't even know any consequences for boys if they make girls pregnant [from consensual unprotected sex].
>
> (Key informant interview)

believe that seeking an abortion is not a '*right of the woman*'. Further research is required to understand what shapes these social attitudes and how access to safe abortion can be increased.

Impacts

Impacts of adolescent pregnancy in Rwanda are interrelated, interdisciplinary and compounding, often affecting multiple capability outcomes for adolescents, including but not limited to those identified in Table 1.

The consequences of adolescent pregnancy are gendered and for girls can include education interruption, stigma and isolation, and numerous serious health consequences. It is understood to be the female's responsibility to prevent a pregnancy (Isimbi et al., 2017), and every informant highlighted significant differences in the implications of adolescent pregnancy for boys compared to girls: *'I don't even know any consequences for boys if they make girls pregnant [from consensual unprotected sex]'* (key informant).

Adolescents may turn to unsafe means to try to terminate unwanted pregnancies, such as traditional herbs or various medicines (Umuhoza et al., 2013). Every respondent listed unsafe abortions as a consequence of adolescent pregnancy. Many adolescents who require treatment for abortion complications will not receive any post-abortion care at all (Basinga et al., 2012a).

There are many economic impacts of pregnancy, including the costs of abortion or post-abortion care, but especially the costs of raising the child if the pregnancy is not terminated. Without family, social and financial support, adolescents often lack information on how to take care of their babies and struggle to earn money. Additionally, adolescent pregnancy can lead to imprisonment of those caught having an abortion outside the legal exemptions, and, less frequently, of men who are reported for sexual abuse. Adolescent dependence on others for financial support can also lead to adolescents choosing not to press charges against a rapist if he is assisting with the financial costs: *'It challenges them to choose between "do I report or do I keep quiet and keep receiving the support from the father?"'* (key informant).

Due to the fear of judgement associated with the stigma of single-motherhood, adolescent pregnancy can also lead to a mother not completing her child's legal birth registration.

Interventions

As is evident in Table 2, most interventions address health, nutrition and SRH, followed by voice and agency, and education and learning. There is, however, a significant gap in services for psychosocial well-being and economic empowerment. Overlooking the psychosocial needs of adolescents is problematic, as the impacts of adolescent pregnancy such as stigma, isolation and lack of social support cannot therefore be sufficiently addressed. Moreover, the lack of focus on economic empowerment perpetuates poverty and financial constraints, which drive and impact adolescent pregnancy.[3]

Table 1: Impacts of adolescent pregnancy on GAGE capability outcomes

	Education and learning	Health, nutrition and SRH	Bodily integrity	Psychosocial well-being	Voice and agency	Economic empowerment
Education interruption	✓	✓		✓	✓	✓
Stigma and isolation	✓	✓		✓	✓	
Loss of home and cohabitation	✓			✓	✓	✓
Health complications	✓	✓	✓	✓	✓	✓
Unsafe abortions	✓	✓	✓	✓	✓	✓
Imprisonment	✓	✓	✓	✓	✓	✓
Financial loss and stress	✓			✓	✓	✓
Child registration		✓	✓	✓	✓	

3 Interventions are mapped using a non-systematic method. The capability outcomes addressed by these interventions include but are not limited to those identified in Table 2.

Table 2: Evaluation of interventions using GAGE capability outcomes[4]

	Education and learning	Health, nutrition, and SRH	Bodily integrity	Psychosocial well-being	Voice and agency	Economic empowerment
Health systems						
Youth Corners at health centre level		✓				
Rwandan Adolescent Reproductive Health Initiative		✓				
Expansion of services through community health workers		✓				
Education						
Comprehensive sexuality education	✓	✓				
Sexual Health Reproductive Education (SHARE) programme	✓	✓			✓	
My Changing Body programme		✓			✓	
GrowUp Smart, an interactive puberty education program under the Expanding Family Planning Access, Availability and Awareness (A3) Project		✓			✓	
The Christian Initiative of Education for Sustainable Peace and Development (CIESPD)	✓			✓	✓	
Empowering Adolescent Girls through Education programme or Programme Partnership Agreement 2 (PPA2)	✓		✓		✓	
Skill development and employment						
Adolescent Girls Initiative (AGI)	✓					✓
SPRING Accelerator	✓	✓	✓			✓
Financial Education and Life Skills (FELS)	✓	✓			✓	✓
The Firelight Foundation Adolescent Girl Programme	✓				✓	✓
Multidimensional						
Isange One-Stop Centres, located in public hospitals		✓	✓	✓		
DREAMS-Like Program	✓	✓	✓			
A-SRH Project	✓	✓	✓			
mHealth and other ICT						
Kasha Rwanda, e-commerce platform		✓			✓	
CyberRwanda		✓				
m4RH—Mobile for Reproductive Health		✓				
Ni Nyampinga	✓	✓			✓	
Mentorship/dialogue/safe spaces						
Ni Abacu Programme		✓	✓		✓	
12+ programme, a mentorship and safe-space programme		✓	✓		✓	
Tuseme ('speak out') clubs	✓				✓	
Behavior Change and Social Marketing (BCSM) Project		✓			✓	
Sugar Daddies Risk Information Programme		✓	✓			
Total	**12**	**20**	**8**	**2**	**14**	**4**

16-year-old adolescent girl who is pregnant in Rwanda © Nathalie Bertrams/GAGE 2020

The capability outcomes addressed by these interventions include but are not limited to those identified in Table 2. Moreover, while the interventions in this table have been categorised under different themes, there are many overlaps. Table 3 highlights the different levels or contexts that interventions address.

4 The detailed mapping of interventions, with information on the target groups, length, scale, delivery channel, aims, main components and evaluations, is available in the complete report submitted to GAGE-ODI by the LSE team.

Table 3: Evaluation of interventions using GAGE contexts

	Adolescents	Peers	Household	Community	Government
Health systems					
Youth Corners	✓	✓			
Rwandan Adolescent Reproductive Health Initiative				✓	✓
Expansion of services through community health workers				✓	✓
Education					
CSE	✓	✓			
SHARE	✓	✓			
My Changing Body	✓	✓	✓		
GrowUp Smart	✓	✓	✓	✓	
CIESPD					
PPA2	✓	✓	✓	✓	✓
Skill development and employment					
AGI	✓				
SPRING Accelerator	✓				
FELS	✓	✓			
The Firelight Foundation Adolescent Girl Programme	✓	✓		✓	
Multidimensional					
Isange One-Stop Centres	✓			✓	
DREAMS-Like Program	✓			✓	
A-SRH Project					
mHealth and other ICT					
Kasha Rwanda, e-commerce platform	✓				
CyberRwanda	✓	✓	✓	✓	
m4RH	✓				
Ni Nyampinga	✓	✓			
Mentorship/dialogue/safe spaces					
Ni Abacu Programme	✓	✓	✓	✓	
12+	✓	✓		✓	✓
Tuseme ('speak out') clubs	✓	✓			
BCSM	✓	✓		✓	
Sugar Daddies Risk Information	✓	✓			

Interventions can successfully address these capability outcomes in the different contexts adolescents are placed in if they meet the five key principles underpinning the effective delivery of services adapted from Engel et al. (2019). Table 4 demonstrates how none of the interventions meet all five principles.

Table 4: Evaluation of interventions using a framework adapted from Engel et al. (2019)

	Equity in access	Quality of care	Accountability	Multi-sectorality	Meaningful engagement of adolescents, parents and community
Health systems					
Youth Corners					
Rwandan Adolescent Reproductive Health Initiative					
Expansion of services through community health workers					
Education					
CSE					
SHARE					
My Changing Body					
Growup Smart					
CIESPD					
PPA2					
Skill development and employment					
AGI					
SPRING Accelerator					
FELS					
The Firelight Foundation Adolescent Girl Programme					
Multidimensional					
Isange One-Stop Centres					
DREAMS-Like Program					
A-SRH Program					
mHealth and other ICT					
Kasha Rwanda, e-commerce platform					
CyberRwanda					
m4R					
Ni Nyampinga					
Mentorship/dialogue/safe spaces					
Ni Abacu					
12+					
Tuseme ('speak out') clubs					
BCSM					
Sugar Daddies Risk Information Programme					

Yes	No	Somewhat	Insufficient evidence

Adolescent girl in Rwanda © Nathalie Bertrams/GAGE 2020

Equity in access

Interventions should be inclusive in delivery platforms and reduce geographic/physical, economic, cognitive (awareness) and psychosocial (stigma) barriers to access (Engel et al., 2019; Thongmixay et al., 2019). Most interventions mapped reduce only some types of access barriers. Most interventions mapped (14 out of 15), for which the target age group is published, include very young adolescents (aged 10–14). The 12+ programme specifically aims to provide mentorship and a safe community space to very young adolescent girls who have unique needs as they experience rapid physical, social, emotional and cognitive changes (Woog and Kågesten, 2017). However, in the majority of interventions, components with dedicated services are absent for vulnerable groups with unique needs, such as adolescents with physical, cognitive or emotional disabilities, those who are refugees or internally displaced, those who belong to single-parent households, LGBTQ and gender-diverse adolescents or adolescents engaged in precarious occupations, such as paid domestic work. The needs of out-of-school adolescents are also not sufficiently addressed. Furthermore, the lack of focus on boys in many interventions perpetuates the idea that it is the girls' responsibility to prevent pregnancy and deal with its impacts.

There are significant gaps in the geographic coverage of interventions, limiting their accessibility. More than half of the mapped interventions for which information on scale is published have a presence in less than 10 districts. For interventions that are implemented in all 30 districts in Rwanda, there is limited information on the distribution of facilities in each district. While the use of digital platforms can overcome geographic access barriers and also circumvent psychosocial barriers by ensuring greater privacy and confidentiality, they exclude the poorest adolescents who cannot afford digital devices (Bacchus et al., 2019; Feroz et al., 2019). There is a lack of sufficient evidence on mechanisms to ensure anonymity and confidentiality across most interventions. Lastly, most evaluations conducted do not stratify results by socio-economic indicators or other vulnerabilities, which is crucial to determining equity in access (Denno et al., 2015).

Quality of care

Staff shortages, high rates of attrition, high workload and burn-out, low salaries and limited career growth opportunities, especially in rural areas, can significantly impact the motivation levels of staff and the quality of care in health facilities (Odhiambo et al., 2017; Condo et al., 2014). There are significant gaps in incentive structures

for community health workers and their training on youth-friendly service provision (Condo et al., 2014). Attitudes of stigma, judgement by staff, and lack of privacy and anonymity in health centres continue to affect the quality of care received by adolescents. Overall, there is a lack of sufficient information on the nature, duration and intensity of training on youth-friendly services given to healthcare providers. Moreover, further research is needed on whether there is any difference in the quality of care between services provided by the government and those provided by faith-based or private organisations.

Comprehensive sexuality education (CSE), which is implemented nationally by the Ministry of Education at the primary-school level, integrates ASRHR education in the competence-based curriculum (2015) in an *'age-appropriate, culturally and gender sensitive manner'* (Rwanda Education Board, 2015: 22). It aims for ASRHR to be understood holistically and not in silos. However, in the way CSE is implemented, there is a continued emphasis on abstinence. Furthermore, as stated by an informant, CSE does not enable dialogue or questions in the classroom, which undermines its quality. Finally, the teachers' personal beliefs can hinder the quality of CSE, as they are responsible for selecting what information to share and how to present it (Gallant and Maticka-Tyndale, 2004).

Evaluations of interventions emphasise scale and outputs, omitting information on facility characteristics, and staff attitudes and behaviour, which are important to determining the quality of care.

Accountability

A clear mechanism of downward accountability was seen only for community health workers, as they are elected by the community (Condo et al., 2014). Most interventions seemingly have only upward accountability mechanisms. There is a lack of sufficient platforms for feedback from adolescents or the community to hold service providers or decision-makers accountable.

Multisectorality

Interventions with synergy across sectors are more effective (Engel et al., 2019). While most interventions mapped in our study consist of partnerships between the government, international organisations, NGOs and private actors, they operate in sector-based silos (i.e. only in the education or health sectors). Furthermore, as found in the 12+ programme, a challenge in implementing multisectoral programmes is the involvement of multiple stakeholders leading to complex programme governance structures. More streamlined processes for monitoring and evaluation are crucial when adopting multisectorality.

Meaningful engagement of adolescents, parents and the community

Effective interventions meaningfully engage actors across all levels of the socio-ecological framework and at all stages of the intervention. The mapped interventions (except for CyberRwanda) do not engage adolescents, parents and the community as equal partners in decision-making during the design, implementation or monitoring and evaluation stages. This is critical in ensuring that interventions are aligned with the unique needs of adolescents and local realities (Caffe et al., 2017).

Policy and programming implications

Meeting the needs of sexually active adolescents who do not want to become pregnant is extremely challenging and requires the involvement of social, cultural, political, economic and health systems (Coast and Fetters, 2017). There is considerable space for civil society actors to work alongside the government to strengthen the support adolescents receive in accessing ASRHR services.

Various compounding drivers, patterns and impacts of adolescent pregnancy result in the suppression of capability outcomes. Recent efforts to ease access to legal abortions are commendable, but more needs to be done to meet adolescent ASRHR needs. It is critical to include boys and men at all levels of interventions, especially since many drivers, patterns and impacts of pregnancy are embedded in gender norms and inequities.

Improving sex education and contraceptive use

As consensual peer sex is a common driver, adolescent pregnancy is related to what information adolescents have and what contraception they have stigma-free access to. Delivering effective ASRHR programming, including CSE, is complex and requires complementary approaches to be implemented concurrently in order to achieve success. Interventions geared towards supporting ASRHR need to continue to include men and boys and adopt a gender-transformative approach (Ruane-McAteer et al., 2019) to address the root causes of gender-based health inequities and prevent perpetuation of the idea that girls are solely responsible for preventing pregnancy. Promoting an environment that is less tolerant of sexual coercion is important. The media can play a role in this, by developing TV shows/radio/movies that do not depict women as submissive and men as dominant, and that problematise forced sex, especially for adolescents (Van Decraen et al., 2012).

To prevent unwanted or unplanned pregnancies at the point of conception:

- General recommendations:
  - Expand research on interventions that target gender perceptions and intergenerational or hierarchical norms across adolescent contexts.
  - Support community and intergenerational dialogue and sensitisation efforts to shift norms around adolescent health issues and gender perceptions.
  - Reduce unmet need by subsidising emergency contraception and improving its district-level accessibility.
  - Strengthen the implementation of Rwanda's CSE curriculum by improving teacher training to ensure the comprehensive delivery of information and encouragement of student dialogue and questions; and integrating healthcare workers trained in youth-friendly service provision to diversify providers of CSE and help prevent teacher bias from impacting delivery.
  - Improve incentive structures for community health workers to enhance their motivation and the quality of care in service delivery.
  - Provide downward accountability mechanisms, which include adolescents, parents and the community, to improve quality of care and access.
- Legal recommendations:
  - Add a close-in-age exemption to the Rwandan Penal Code to prevent the prosecution of consensual sex for two individuals below 18.
  - Reduce the legal age requirement to obtain parental consent for ASRHR services to adolescents aged 14 years and under.

Pregnancy: seeking care

To reduce delays in care-seeking by pregnant adolescents:

- General recommendations:
  - Support further research on current service provision, potentially through the publicised use of undercover researchers posing as clients. This is a practical and adaptable method of research, and improves quality of care (Van Den Borne, 2007).
  - Include youth-friendly service provision training in all professional education programmes such as medical school, nursing school, community health worker training, teacher certification and law enforcement training.
  - Complete further research to gain a better understanding of the gaps in evidence around current training programmes.
  - Support collaboration among civil society organisations and help bolster their voices to combat stigma and gendered perceptions of ASRHR.
- Legal recommendations:
  - Amend the Professional Code of Ethics to remove healthcare providers' ability to refuse to provide care based on their *'personal moral convictions'* (Påfs et al., 2020), to prevent discrimination.

Accessing legal and safe abortions

Momentum from Rwanda's recent expansion of laws to legalise abortion (Påfs et al., 2020) needs to be capitalised on. A unique window of opportunity exists for

abortion advocates, as policymakers are demonstrating an increased awareness of the importance of this issue (Herrera, 2019). When abortion is provided in a safe, accessible and legal manner, women's health indicators significantly improve. Furthermore, the beneficiaries of abortion are not just women: they include their children, families and society as a whole in the present and for the future (Grimes et al., 2006). Since adolescents will continue to seek abortions, removing restrictions to safe abortion access is imperative for preventing negative health consequences and/or unwanted motherhood.

Improve adolescent abortion access by:

- General recommendations:
  - Increase the awareness of law amendments providing increased rights and access to safe abortions.
  - Improve financial accessibility of legal abortions.
- Legal recommendations:
  - In line with WHO recommendations, allow mid-level practitioners who may have not obtained a certificate from the Ministry of Health to perform abortion services, in order to reduce burdens on healthcare providers in Rwanda (Vlassoff et al., 2015).
  - Amend legal barriers/contradictions in the Law on Reproductive Health and the Rwandan Penal Code by: defining adolescents in legislative policies and advocating for adolescent rights under international conventions ratified by Rwanda; removing the parental consent requirement for legal abortions for adolescents aged 15 or over; and removing prohibitions on advertising abortion services to spread awareness to adolescents.

18-year-old adolescent mother in Rwanda © Nathalie Bertrams/GAGE 2020

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