

# First Time Young Mothers in Rwanda

## Baseline Study

---

## Table of Contents

Introduction .....	1
Country context .....	1
Rationale for the First Time Young Mothers intervention .....	2
Objectives of the baseline study.....	3
Methodology.....	4
Sampling .....	4
Quantitative data collection .....	4
Qualitative data collection .....	5
Data analysis.....	5
Limitations .....	5
Findings .....	6
Demographics .....	6
Social and economic conditions .....	6
Relationships.....	8
“Beatha’s” story.....	10
Use of maternal and child health services.....	11
Use of modern contraceptive methods.....	12
Experience of violence and discrimination .....	14
“Immaculee’s” story .....	17
Conclusions .....	18
Recommendations .....	18
Annex I: SURVEY QUESTIONNAIRE .....	20
Annex II: FOCUS GROUP DISCUSSION GUIDE .....	27
Annex III: KEY INFORMANT INTERVIEW GUIDE .....	28

## Introduction

In every region of the world, poor, rural and girls with low education have higher risk of becoming pregnant than their wealthier, urban, educated counterparts. Girls from minority or marginalized groups, who lack choices and opportunities in life, or who have limited or no access to sexual and reproductive health services, are most at risk.

Most of the world's births to adolescents—95 per cent—occur in developing countries, and nine in 10 of these births occur within marriage or union. About one in five young women in developing countries become pregnant before age 18, which translates into 7.3 million births every year<sup>1</sup>. About 70,000 adolescents in developing countries die each year from complications during pregnancy and childbirth. Girls who become pregnant before the age of 15 in low and middle income countries have double risk of maternal deaths than older women<sup>2</sup>.

Adolescent mothers are at risk of severe reproductive morbidities, including obstetric fistula. Up to 65% of women with obstetric fistula develop this as adolescents, with dire consequences for their lives, physically and socially<sup>3</sup>.

Although adolescents aged 10-19 years account for 11% of all births worldwide, they account for 23% of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth. Fourteen percent of all unsafe abortions in low- and middle-income countries are among women aged 15–19 years. About 2.5 million adolescents have unsafe abortions

every year, and adolescents are more seriously affected by complications than are older women. Stillbirths and death in the first week of life are 50 percent higher among babies born to mothers younger than 20 years old than among babies born to mothers 20–29 years old<sup>4</sup>.

In addition to the physical risks to mother and child, the pregnancy often means an end to their education, limited opportunities for economic participation, and a premature and abrupt end to childhood. Adolescent pregnancy has negative effects on girls' physical, economic, mental and social wellbeing - as it frequently leads to discrimination and stigma.

Adolescent pregnancy also threatens girls' human rights. When girls are denied access to information and services they need to prevent pregnancy, their autonomy is undermined. When an adolescent girl is denied contraception, her right to health is violated. When they become pregnant and forced out of school their right to education is denied. When girls drop out of school it negatively affects not only themselves, but their children, families and society at large.

## Country context

Over the past 10 years, adolescent fertility in Rwanda has slightly increased. Adolescent childbearing is at 7.3%. At age 19, one in five Rwandan girls are mothers or pregnant with their first child. Girls with no education and primary education have higher birth rates than their more

---

<sup>1</sup> UNFPA.2013.State of World Population 2013. Motherhood in Childhood. New York: UNFPA

<sup>2</sup> Framework for Action for the follow-up to the PoA of the ICPD Beyond 2014. p. 82 New York: UN 2014.

<sup>3</sup> WHO. [http://www.who.int/maternal\\_child\\_adolescent/topics/maternal/adolescent\\_pregnancy/en/](http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/)

<sup>4</sup> Ibid.

educated, affluent counterparts<sup>5</sup>. The legal age of marriage in Rwanda is 21. The number of women who reported marriage by age 18 is 14%; this number has been steadily decreasing<sup>6</sup>. However, it is not known how many girls are living in informal unions or in religious marriages without civil registration. It is assumed that unplanned adolescent pregnancy contributes to a significant percentage of marriages below 18.

Although socially frowned upon, a significant proportion of Rwandans are sexually active before marriage. 23.6% of girls aged 18 – 19 report that they had sex before the age of 18, and 28.1% of boys. Use of condoms and other contraceptives is still low in this age group. Only half of sexually active young girls (15-19) report that they used a condom at last sexual intercourse. Similarly, only 32.8% of sexually active girls 15 – 19 years old are using a contraceptive method<sup>7</sup>. Although little data is available, young women in Rwanda seem to have higher rates of unsafe abortion than older women. One prospective study conducted in a single Kigali hospital of women who admitted having had an unsafe abortion, found that most were younger than age 25, unmarried and pregnant for the first time. Another study found that 90% of those serving time in one prison in the South for induced abortion were younger than 25<sup>8</sup>. Rwanda has continuous high rates of sexual and gender based violence. One in six Rwandan women aged 15 - 19 and

one in four women aged 20 – 24 has experienced sexual violence<sup>9</sup>. However it is not well known how much sexual violence contribute to adolescent pregnancies.

### Rationale for the First Time Young Mothers intervention

Despite efforts in recent years to expand youth – friendly SRH services, young people’s access to quality services remains limited. The First Time Young Mothers (FTYM) project will introduce a new intervention targeting FTYM between the ages of 10 - 19. The long- term objectives of the project will be focused on improving maternal health and newborn care among FTYMs, including use of family planning to prevent subsequent unintended pregnancies and promoting adequate birth spacing.

Antenatal care attendance during pregnancy is important to identify and mitigate risk factors in pregnancy, especially for pregnant adolescents under 15, and to encourage women to have a skilled attendant at childbirth. Antenatal care should be initiated early enough and follow the four recommended visits. However, many pregnant women in developing countries start antenatal care attendance late, particularly adolescent pregnant women. Given the risks of a fast subsequent pregnancy to mother and child, it is important that the postpartum care includes modern method family

---

<sup>5</sup> National Institute of Statistics of Rwanda, Ministry of Health, Rwanda, and ICF International. Rwanda Demographic and Health Survey 2014 – 15.

<sup>6</sup> Ibid

<sup>7</sup> National Institute of Statistics of Rwanda, Ministry of Health, Rwanda, and ICF International. Rwanda Demographic and Health Survey 2014 – 15.

<sup>8</sup> Basinga et al. (2009). Unintended Pregnancy and Induced Abortion in Rwanda: Causes and Consequences. Guttmacher Institute.

<sup>9</sup>National Institute of Statistics of Rwanda, Ministry of Health, Rwanda, and ICF International. Rwanda Demographic and Health Survey 2014 – 15.

planning services for those who wish to space pregnancies or prevent unwanted pregnancies.

Access to a quality SRH-package of services with appropriate support and counselling for young mothers will protect their health and wellbeing and improve the wellbeing of their new-borns. As the health care delivery platform will remain the same as for all women of reproductive age, systems-wide quality improvements for maternal health services including ANC, natal, and post-partum care is important to have expected results for this subgroup.

Little data is available on young people's use of health services. The information available comes from national surveys such as the DHS. Thus, no data is available on whether the utilization of SRH and child health services by FTYM differs from that of the general population. Furthermore, no research on the social conditions and needs of FTYM in Rwanda is available, but anecdotal evidence indicates that adolescent girls who give birth are subjected to various forms of discrimination and stigma, such as being expelled from school and social exclusion in their communities.

Before implementation of the new project, a baseline study was conducted to better understand the circumstances surrounding adolescent pregnancy in Rwanda, FTYMs perceptions and use of health services, their social and economic conditions and their support needs.

## Objectives of the baseline study

- To determine ANC attendance by FTYMs in the targeted districts, disaggregated by age compared to all women of RH age
- To determine percentage of Skilled Birth Attendance among FTYM
- Assess post- partum use of Family Planning services by FTYM in the targeted districts disaggregated by age.
- Assess the perceptions of FTYM regarding using modern contraceptives and other sexual and reproductive health services.
- Assess the social needs of FTYM

## Methodology

The study used a cross-sectional methodology that included both quantitative and qualitative techniques. Quantitative analysis was used to determine access and use of SRH services by FTYM, while qualitative analysis was used to understand perceptions of the study population about SRH matters, including family planning.

## Sampling

The research aimed at reaching a representative sample of FTYM in UNFPA targeted districts. A sample was computed to reach a 95% confidence level for estimation of population parameter for a single percentage.

Sample calculation

$$n = \frac{Z^2 p(1-p)}{D^2}$$

Where: n is the sample size, Z is the statistic corresponding to level of confidence (1.96), P is expected prevalence (21%), and D is precision (5%).

$$n = \frac{(1.96)^2 \times (0.21)(1 - 0.21)}{(0.05)^2} = 252$$

Participants who were interviewed were recruited from three selected districts that have the highest rates of adolescent pregnancies among the five UNFPA intervention districts. The 3 districts selected were Rubavu, Nyamasheke and Rusizi.

A sample size of FTYM was allocated to each district to be recruited from different sectors. The interviewees were also divided in two groups of those living in rural and urban areas. The classification

was done by local leaders familiar with the area.

## Quantitative data collection

Primary data collection was done using survey questionnaires with selected FTYM. A team of one Imbuto Foundation staff member and two hired enumerators were allocated to each of the three districts. The enumerators were all female and experienced with data collection for health related surveys.

District authorities were informed about the baseline and its purpose and helped identify sectors within their districts with high rates of adolescent pregnancy.

At the sector level, local leaders helped facilitate the contact with cell leaders (the lowest level of public administration in Rwanda) who in turn helped identify FTYM to be recruited. Girls who were recruited were young women who had given birth between the ages of 10 to 19. Participants were then invited to come for the interview at the cell office. None of the invited FTYM declined to participate in the survey. Unexpectedly, a higher number of girls than those who were invited came to the cell office and some were sent home because the number of the sample was reached.

Before the interview, the enumerator explained the objective of the study and highlighted that it was confidential and voluntary. Informed consent was obtained verbally. No identifying information was recorded and no pictures were taken.

Interviews were conducted at the cell office in a hall or small offices, or a garden depending on the availability of the rooms. During the interview, only the interviewer and the respondent were present to ensure confidentiality and allow respondents the freedom to express

themselves without fear of being heard. The questionnaire is included in this report as Annex I.

### Qualitative data collection

Two Focus Group Discussions were conducted in each district. Each FGD had six – eight participants, consisting of girls who had given birth when they were between ages 10-14 and those who had been between ages 15-19, respectively. The objective of the FGDs was to assess their understanding of SRH, their attitudes and the challenges they perceive as FTYM in their respective communities.

The FGDs were carried out by Imbuto Foundation a staff member with help of a data enumerator. The participants from FGDs were identified by the cell and village leaders with the help of CHWs in the same way as those participating in the survey. The FGDs were also conducted either in an office, a hall or in the garden ensuring that no one else in the area was listening.

KIIs were conducted with local leaders at sector and cell level, nurses from nearby health centers who were providing services targeted at adolescents and youth secondary school teachers and parents, preferably one who has a daughter who experienced an adolescent pregnancy. Focus Group Discussion and Key Informant Interview guides are included in this report as Annex II and III, respectively.

### Data analysis

Analysis of quantitative data was done using descriptive statistics; percentages, mean and standard deviation. Respondents who were 25 years old and older were excluded from the sample during analysis. As their experiences as

FTYM occurred minimum five years before the survey, the chance of recall bias was considered high, additionally, their experiences with the health services during that time may be less relevant for the situation today.

The data collected from FGDs (Focus Group Discussions) and KIIs (Key Informant Interviews) coded according to themes emerging from the data and synthesized into narrative text. The qualitative data was triangulated with results from quantitative analysis to answer the “whys” that could not be answered by quantitative analysis.

### Limitations

Matters related to adolescent SRH are complex and sensitive in the Rwandan context, and cannot be fully analyzed by this simple cross-sectional study. The limited funds available for this exercise did not allow for a bigger sample size and this limited the depth of analysis which could be performed.

## Findings

### Demographics

The survey respondents in the study were between 15 and 24 years old. 58% of respondents were between 15 – 19 years old and 41.7% were between 20 – 24 years old. The respondents were evenly distributed between the three districts Rubavu, Rusizi and Nyamasheke, in the Western Province of Rwanda. The majority of survey respondents lived in a rural area (63.9%).

Table 1: Respondent ages (n=266)

Age	Percent	Cumulative Percent
15	.8	.8
16	7.5	8.3
17	6.8	15.0
18	13.9	28.9
19	29.3	58.3
20	16.9	75.2
21	7.9	83.1
22	9.4	92.5
23	3.8	96.2
24	3.8	100.0

The majority of respondents lived with their parents. A large percentage lived with their mothers, fewer lived with their fathers. There were no significant differences in household composition between the age groups (Table 2). Almost all (97.5%) of respondents lived with their own children.

Table 2: Current members of respondents' households by age group (n=266).

Age group	Mother	Father	Grandparent(s)	Other children/siblings	Spouse/Partner	Lives alone	Other adult relatives
14 - 19	74.2	41.3	8.4	58.1	0.6	3.2	10.3
20 - 24	82.9	42.3	6.3	59.5	0.0	0.9	18.9
Total	77.8	41.7	7.5	58.6	0.4	2.3	13.9

Most girls who participated in Focus Group Discussions also reported that they lived at home with their families. All of them lived with their own children.

### Social and economic conditions

The majority of survey respondents reported primary school as their highest educational attainment, while about one in five had attended lower secondary school. A small percentage had attended upper secondary school (Figure 1). Educational attainment was higher among respondents residing in urban areas compared to rural areas (Table 3).

Figure 1: Educational attainment

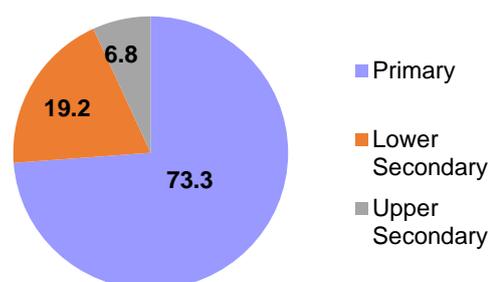


Table 3: Level of education by residence (%) (n=266)

	Primary	Lower Secondary	Upper Secondary
Urban	67.7	24.0	8.3
Rural	77.4		16.7
			6.0

The majority of participants (95.3%) had got pregnant with their first child between the ages of 15 – 19 (Figure 2). Half of respondents (133/266) said they left school when they got pregnant. The percentage who said they dropped out increased slightly with the age of the first pregnancy (46.2% among those who were between 12 – 14 years compared to 51.9% among those who were 18 – 20 years). Out of those, only 4.9% returned to school after giving birth. Early pregnancy was associated with lower educational attainment (Table 5). Given that nearly three quarters of respondents reported primary school as their highest level of education, it is assumed that many participants were already out of school at the time they got pregnant.

**Table 4: Level of education by age at first pregnancy (%) (n=266)**

Age at first pregnancy	Primary	Lower secondary	Upper secondary
12 - 14	100	0.0	0.0
15 - 17	76.9	17.1	6.0
18 - 20	68.4	23.3	8.3
<b>Total</b>	<b>73.8</b>	<b>19.4</b>	<b>6.8</b>

The large majority of survey respondents were currently neither enrolled in school or vocational training, nor formally employed. As expected, slightly more respondents in age category 15 – 19 were currently enrolled in school, compared to those in age category 20 – 24 (Figure 3).

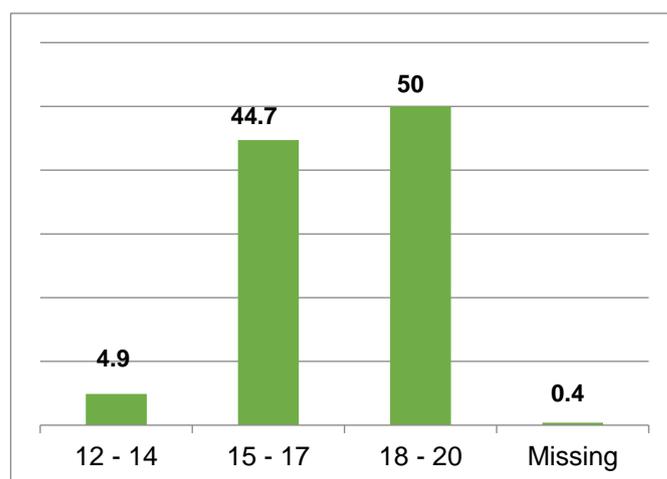
**Table 5: School and employment enrolment (%) (n=266)**

	School	Vocational training	Gainfully employed
No	96.5	97.9	98.9

Yes	3.5	1.8	1.1
Missing	0	0.4	0

About two thirds of survey respondents said their main source of income was “casual labour”; cultivating other people’s land, rearing other people’s animals, selling fruits and vegetables, doing domestic work for others or other odd jobs. The remaining relied on parents or guardians to provide for them. A few individuals said they relied on charity from neighbours or Christian organizations for their survival. The same held true for participants in FGDs.

**Figure 2: Respondents’ age at first pregnancy (%) (n=266)**



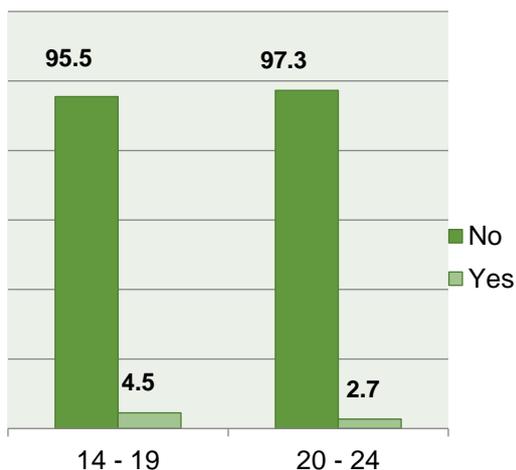


Figure 3: Current school enrolment by age

*Our families are mostly poor because neither our parents nor we have any jobs; we only get food or meet our basic needs when we are able to get a part time job such as digging land for others or washing. Generally, our daily wage varies between 1000 and 1500 RWF (1.2 – 1.7 USD). Sometimes we cannot get these kinds of jobs. We used to get them in Congo, but currently there are no jobs there due to drought. Now, getting food is a challenge due to drought that affected crops. When we have a stroke of luck, we eat once a day and the same applies for our children<sup>10</sup>*

The participants in FGDs described living in poverty with high level of food insecurity, relying on day labour and eating one meal per day. Further, that a teenage mother “loses all rights” in the family, including to land owned by their parents or families.

### Relationships

The overwhelming majority of respondents reported being single – 99.2% or 264 out of 266 respondents, while two reported being separated from their husbands. When asked about their relationship to the father of their child, about a third of respondents answered that he was their boyfriend, and roughly half responded that they were not in a relationship. A minority of respondents reported the father of the child as a family member, a married man, or their employer.

Table 6: Relationship to child’s father

Relationship to father	Number	Percent
Husband	1	0.4
Boyfriend	90	33.8
I am not in a relationship	136	51.1
Family member	7	2.6
Other	32	12

In FGDs, the majority of girls described getting pregnant as a result of being in a romantic relationship with a boy of their own age. Most girls said the sexual relations were consensual at the time. The girls described that their boyfriends promised to marry them, however when

<sup>10</sup> Focus Group Discussion with women who had given birth between ages 10 – 14, Rusizi District

they got pregnant their boyfriends disappeared. A minority described getting pregnant by their bosses, neighbours, guardians or family friends. Sexual violence and rape was not prevalent among girls in FGDs.

### **“Beatha’s” story**

I am 20 years old and come from Rubavu District. I come from a very poor family and my parents were not able to provide for me and my siblings when I was growing up. I dropped out of school after primary. When I was 18, my cousin offered me a job as a housegirl. I started working for him. I was hoping to earn some money and help my family survive. But after arriving at his house my cousin started to pressure me to have sex with him. I refused but found myself in a situation where I had to either accept to have sex with him or refuse and run away to my family that was depending on me to survive. But before I could decide I was raped by my cousin and became pregnant.

When my cousin found out that I was pregnant, he immediately kicked me out of the house. I went back to my family but when they realized I was pregnant, they also rejected me. My parents and siblings accused me of going to the city to sleep with men, called me a prostitute and they beat me. Then they told me to leave the house. I did not know where to go or who to go to. I went to the local authorities for help and the local leaders finally brought me back to my family’s home. The authorities told my parents that it was my right to live with my family even though I was pregnant.

Later I gave birth and started to find ways to survive with my baby. I feel broken and alone, nobody is supporting me. Wherever I go in the neighbourhood people call me a prostitute and all other bad names.

**Table 7: Father's age at pregnancy (n=266)**

Age	Number	Percent
15 - 19	54	20.3
20 - 24	115	43.2
25 - 29	46	17.3
30 - 34	19	7.1
35 and above	32	12

The majority of the fathers were reported to be between 15 – 24 years at the time the pregnancy occurred. This suggests that most pregnancies occurred as a result of the respondents having either romantic relationships or casual sexual encounters with boys of roughly the same age as themselves.

The majority of girls in FGDs described that they did not know how a pregnancy occurs before it happened; they had not been exposed to SRH messages or used SRH services prior to the pregnancy and birth. They had unprotected sexual intercourse. Some participants said their first thought after they realized they were pregnant was to have an abortion but they did not go through with it.

### Use of maternal and child health services

About half of the survey respondents had the recommended four ANC visits during pregnancy (Table 8). This is slightly higher than the national average of 43.9%<sup>11</sup>. In FGDs, the participants explained that the reasons why some had fewer than the recommended four were finding out late about the pregnancy, hiding and denying the pregnancy until it was no longer

possible, and being ashamed to be identified as pregnant.

**Table 8: Antenatal care (n=266)**

ANC visits	Frequency	Percent
0	1	0.4
1	16	6.0
2	28	10.5
3	88	33.1
4	132	49.6
5	1	0.4

The problems in accessing care mentioned in FGDs were related to being single, as they are required to bring their partner to the Health Centre for ANC. Some girls had to pay a fee to the District authorities to prove that they were single and this was difficult. Some girls were too poor to pay for their hospital fees and relied on charity from their neighbours.

*Delivery in health facility among survey respondents was 98.1%, which is higher than the national average of 89.9%<sup>1</sup>.*

**Table 9: Complications during pregnancy (n=266)**

Age at first pregnancy	Percent
12 - 14	15.4
15 - 17	16.8
18 - 20	18.8
<b>Total</b>	<b>17.7</b>

**Table 10: Complications during delivery (%) (n=266)**

Age at first pregnancy	Percent
12 - 14	7.7
15 - 17	19.3
18 - 20	20.5
<b>Total</b>	<b>19.3</b>

<sup>11</sup> RDHS 2014 - 15

**Table 11: Complications after delivery (%) (n=266)**

	Number	Percent
No	236	88.7
Yes	30	11.3

Table 11 shows that only 16.2% of respondents had a postnatal check-up after delivery, which is much lower than the national average of 43%. 28.6% of the respondent's new-borns received a post – natal check-up which is higher than the national average of 19%<sup>12</sup>. There were no significant differences in post – natal care between participants who lived in rural or urban areas.

**Table 12: Postnatal care (%) (n=266)**

	Maternal PNC	New-born PNC
No	83.8	71.4
Yes	16.2	28.6

**Table 13: Postnatal care by residence (%) (n=266)**

	Urban	Rural	Total
No	85.4	82.9	83.8
Yes	14.6	17.1	16.2

The majority of respondents were satisfied with the care they had received during pregnancy and birth. Most participants in FGDs also said they were happy with the services they were given and said they were treated well by the health workers. However, some said that health workers had ridiculed them and their situation.

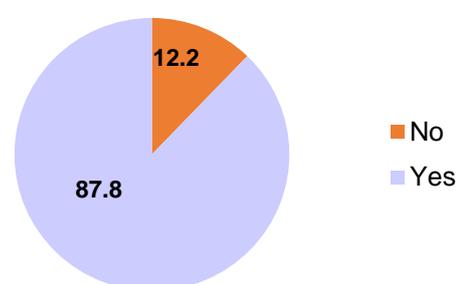
**Table 14: Perception of health workers**

Treatment from health workers	Percent

The health workers treated me with care and respect	58.3
The health workers gave me the necessary attention but nothing more	7.9
The care given was inadequate	7.9
The health workers didn't give me any care	25.9
<b>Total</b>	<b>100.0</b>

The large majority of respondents practiced exclusive breastfeeding for the first six months, which is consistent with RDHS 2014 – 15 findings.

**Figure 4: Exclusive breastfeeding**



### Use of modern contraceptive methods

Table 15 shows that only 34.2% of respondents adopted a contraceptive method after delivery, and among the youngest mothers, the percentage was even lower (23.1%).

Participants in FGDs explained that heard about family planning only after delivery. Few participants were using family planning postpartum, the most common reason why was that they said they do not want to have sex again until they get married.

<sup>12</sup> RDHS 2014 - 15

**Table 15: Postnatal use of contraception (%) (n=266)**

	Age group at first pregnancy			Total
	12 - 14	15-17	18-20	
No	76.9	65.5	64.7	65.8
Yes	23.1	34.5	35.3	34.2

Among those who did adopt a method, injectables and implants were clearly the most popular, accounting for 47% and 35.2%, respectively (Table 16). 82% of those who adopted a method said they got it from a health centre.

**Table 16: Postnatal use of contraception by method (%)**

Modern method	Percent
Standard Days Method	1.1
Injectable	47.3
Pills	7.7
Condoms	7.7
IUD	1.1
Implant	35.2
<b>Total</b>	<b>100.0</b>

*Use of contraceptive methods after delivery was associated with place of residence; 43% of those residing in urban areas adopted a modern method after delivery, compared to only 28.8 of those residing in rural areas.*

Table 18 shows that the majority of respondents stated that they were not sexually active as the main reason why they did not adopt a contraceptive method after delivery. While this may be true for some respondents, it is also possible that it is a result of social desirability bias, reflecting the stigma attached to sex outside of marriage.

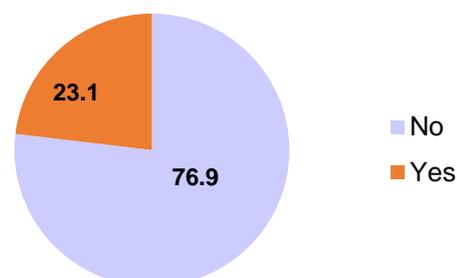
**Table 17: Reason for non- use of contraception**

Reason for non - use	Percent
Fear of side effects	13.2
Religious beliefs	.6
Cost	8.4
I was not sexually active	62.3

Other	15.6
<b>Total</b>	<b>100.0</b>

Current use of contraception among respondents was even lower than after delivery, only 23.1%.

**Figure 5: Current use of contraception**



**Table 18: Desired time to next pregnancy**

	Number	Percent
Less than two years	1	.4
More than two years	131	49.6
I don't want another child	25	9.5
Other	106	40.1
I don't know	1	.4
<b>Total</b>	<b>264</b>	<b>100.0</b>

Nearly all participants wanted to delay their next birth; 46% said they wanted to delay for more than two years and 9.5% said they did not want another child. Out of the 43.2% who answered "other", the most common response was to delay until getting married.

**Table 19: Reason for non-use of contraception for respondents who want to delay next pregnancy**

	Number	Percent
I don't know how to get it	4	2.1
The cost is high	19	9.9
I am afraid of side effects	28	14.6

Religious beliefs	1	0.5
Other	140	72.9
<b>Total</b>	<b>192</b>	<b>100</b>

Among respondents who wanted to delay their next pregnancy but were not using contraception, self – reported abstinence was the most common reason given by those who answered “other”.

### Experience of violence and discrimination

43.6% of survey respondents said they had experienced violence and/or discrimination during their pregnancy (Table 21).

**Table 20: Experience of violence during pregnancy**

	Number	Percent
No	150	56.4
Yes, violence	83	31.2
Yes, discrimination	13	4.9
Yes, violence and discrimination	18	6.8
Missing	2	.8
<b>Total</b>	<b>266</b>	<b>100.0</b>

The majority of the violence took place in their own homes (Table 22). Many participants in FGDs describe being “chased out” by their families when they found out about the pregnancy. The girls describe “extreme anger”, being hated and discriminated against in their families. Some were forced to live with the father of the child, who they said “denied all responsibility” for what happened.

**Table 21: Place where violence occurred**

	Number	Percent
At home	83	72.2
In the community	7	6.1
At home and at school	3	2.6
At home and in community	15	13.0
At school and in community	3	2.6
All of the above	4	3.5
<b>Total</b>	<b>115</b>	<b>100</b>

*I got pregnant by a boy who is 4 years older than me. I met him at work. Because I was pregnant, I was told to leave work and return back home. My boyfriend did not accept the pregnancy and he blocked my calls. When I arrived at home, my pregnancy tore the family apart. Everybody hated me. They hit me, and did not allow me to live in the house with them. I did not have anywhere to sleep or eat. Then my father decided to chase out my mother and me from home. My mother took refuge with a family member and I went to my big sister’s home. The needs grow as the child grows, but I have no one to help me<sup>13</sup>.*

The majority of girls in FGDs were later allowed to return back home, but they describe still being discriminated against by family members and treated differently

<sup>13</sup> Focus Group Discussion with women who had given birth between ages 15 – 19, Nyamasheke District

than their siblings, and they do not have a say in family matters.

Some girls suffered violence from family members. Several girls mentioned being beaten by their parents or brothers during pregnancy and after the birth. One girl said the violence made her suicidal.

*I would buy food and my brothers would throw it away. I always had to flee to the neighbors' houses so that I didn't get beaten or to be able to sleep in peace<sup>14</sup>.*

The participants described being stigmatized and harassed by community members, and being called derogatory names. They described themselves as being outcasts, seen as worthless by others. Many girls expressed being socially isolated. The friends they had prior to getting pregnant are no longer allowed by their parents to see them, as they are seen as a bad influence. They only socialize with other young (unwed) mothers.

*They called us sex workers and our children are named bastards. The family chased us out, we are unwanted and we are told to go away and go far from here where they won't see us<sup>15</sup>.*

On overall, the participants described a difficult life situation, with few opportunities. They are living in poverty, and they have difficulties meeting the basic needs of their children and themselves. They do not have regular employment and they are not in school. Parents do not want to pay school fees for them, as they have "wasted the school fees the first time". The fathers of their children are not assuming any responsibility, and their parents do not support other than letting them live at home. The poverty makes some of them have sex in order to get money or food. They describe being alone with little hope for the future.

The stigma, judgement and harassment from family and community members affect the young mothers psychologically and make them socially isolated.

Regarding their future and what could be done to support them, the young mothers emphasized the ability to sustain themselves and their child(ren) by getting training in vocational skills and help to start a small business or income generating activity, and some would like to return to school. They also emphasized being socially accepted by their families and communities. They wish that people would stop harassing them and to feel included and respected.

---

<sup>14</sup> Focus Group Discussion with women who had given birth between ages 15 – 19, Rubavu District

<sup>15</sup> Focus Group Discussion with women who had given birth between ages 10 – 14, Rubavu District



### **“Immaculee’s” story**

I gave birth when I was 17 years old. I come from a poor family so I dropped out of school to go look for a job, and found one as a housegirl in Kigali. I had a boyfriend and I really liked him. One time he asked me to have sex with him and he promised that I would not get pregnant. When I found out I was pregnant, I was devastated. When I told my boyfriend he ran away and denied that it was his child. I could not continue doing house chores, and I was fired from my job. I went back home to my family. My brothers started beating me and telling me that I was a prostitute. They accused me of lying about being a house girl yet I was selling myself. Because of the violence I came back to Kigali to look for my boyfriend. Then I found out that he has a wife and a family. He threatened me that if I ever told anyone about our relationship, I would die. I did not know where to go since I was also being mistreated by my family back home. I decided to go to another district where I found a shelter run by a Christian organization. I later gave birth living in that shelter, but we did not have enough food. A few months later, my baby started getting very sick because of hunger, so I decided to go back home because I would rather get beaten than seeing my child die of hunger.

When I reached home, the situation had not changed. My child and I were still unwanted. I was also called all bad names by the community. I looked for a job so that I could take care of her child. But whenever I would cook for my child, my brothers would come and pour out the food that I cooked. So I began to cook secretly. My heart was broken but I was determined to take care of my child. Later on, I met another man who said he loved me and my child, and he wanted to marry me and take care of my child. But when I brought him to my parents to introduce him, my mother said loudly: *“You want to get married to a prostitute? Beware of the wrong decision you are making”*. When he heard that statement, he decided to end the relationship. I have given up hope that I will be married one day and have a stable life.

## Conclusions

This baseline study explored First Time Young Mothers in Rwanda's use and perception of health services and their social and economic living conditions and needs.

The findings suggest that use of maternal and child health services by FTYM is comparable to that of other women of reproductive age. Most FTYM were satisfied with the services they had received during their pregnancy, childbirth and postnatal period.

The majority of respondents had become pregnant as a result of a relationship or casual sexual encounter with a young man fairly close to their own age. Sexual violence and exploitation was reported by a minority. The findings suggest that most FTYM in Rwanda are single at the time they conceive and that they stay single after giving birth. Thus, we may assume that most adolescent pregnancies in Rwanda are not a result of child marriage/forced marriage or union.

A very low percentage of FTYM were currently using modern contraceptive methods. Most respondents reported abstinence as their method of choice to prevent a subsequent pregnancy. This may be a result of the social stigma attached to premarital sex and the social condemnation experienced by FTYM. Nevertheless, it is likely to put many of them at high risk of another unintended pregnancy.

The findings indicate that life conditions for many FTYM and their children are very difficult. The vast majority rely on their parents and/or odd jobs for survival. The results show that many FTYM were out – of – school at the time they got pregnant. Very few of those who were in school, the

pregnancy and birth put an effective stop to their education.

FTYM in FDGs also describe having difficulties in feeding themselves and their children. This is likely to also affect the healthy growth and development of their children.

Further, the findings indicate that FTYM are subject to social marginalization and discrimination in different ways. Almost half of respondents report being subjected to violence and discrimination, one in three had been subjected to violence. Most of the violence took place at home. In FDGs, FTYM also reported social exclusion and frequent harassment against themselves and their children by community members.

## Recommendations

Increased attention should be given to counselling and provision of contraceptive methods of their choice to adolescent mothers. The counselling should be initiated during ANC and continued during the intrapartum and post – partum period. Long – acting reversible methods of contraception are highly effective in preventing unintended pregnancies and should be included in the methods offered to FTYM.

The requirement of male accompaniment to ANC should be considered removed for pregnant women below the legal age of marriage (21 years) as these women are likely to be single. The requirement thus poses a barrier to access care.

The respondents in this study reported very limited knowledge of sexual and reproductive health, including contraceptive methods, before getting pregnant. This highlights the need for strong investment in Comprehensive

Sexuality Education for both in- and out-of- school adolescents.

Further, it is crucial to increase awareness of and access to contraceptive methods for unmarried adolescent girls to prevent unintended pregnancies. This includes removing legal barriers such as parental consent for adolescent girls below the age of majority.

The findings of this study also indicate that adolescent mothers and their children endure high levels of food insecurity due to poverty. In the case of adolescent mothers, the poverty is exasperated by the fact that many are rejected by their families and other social protective structures which may exist in their local communities. There is need for health and social services to consider the vulnerable situation of adolescent mothers and provide nutritional and other support to their children to decrease the risk of malnutrition and long – term negative developmental outcomes.

The findings of this study reveal widespread social discrimination of adolescent unmarried, which also affects their children. Even more grave is the high levels of reported violence. There is a need for targeted interventions on the community level to protect adolescent girls and their children from violence and discrimination and secure that their human rights are respected.

The findings of this study indicate that it is necessary to work both directly with the families of adolescent mothers, as well as the larger community to change attitudes. Important stakeholders such as the school system, local and religious leaders must be sensitized and engaged to improve the living conditions of adolescent mothers and their children.

## Annex I: SURVEY QUESTIONNAIRE

Number: .....

Date of interview: .....

*To answer this questionnaire, please fill the blank spaces provided or check the box most appropriate to you, or complete the statement in the space provided.*

### Section I: Demographic/Socio - Economic Information

District: .....

Sector: .....

Health center:

Respondent's year of birth: .....

*If respondent does not know, ask for approximate age.*

1. With whom are you living now? (Tick all that apply)

- Mother
- Father
- Grandparent(s)
- Other adult relatives
- Other children / siblings
- Spouse / Partner
- Other adult non-relatives
- No one (I live alone)
- My own children

2. Number of years of education attained so far

- 0– 3
- 4 – 6
- 7– 9
- 10 – 12
- 13 and above

4 Are you currently enrolled in school or a vocational training program?

- Yes
- No

5 Are you currently gainfully employed?

- Yes
- No

6 What is your main source of income?

- Work

- Parents/guardian
- Husband/partner
- Other, please specify.....

7 Relationship status:

- Never in union/Single
- Married
- Living with partner
- Boyfriend
- Other.....

8 How old is your child now?

- 0-6 months
- 7 months- 1 year
- 2-6 years
- 7 years – above

9 Did you leave school when you got pregnant?

- Yes
- No
- I don't want to answer

10 If yes, what was the reason?

- Expelled
- I didn't want to go
- I got ill because of the pregnancy
- Parents stopped paying for my schools fees
- Others, please specify.....

11 If yes, were you able to return to school after giving birth?

- Yes
- No
- I don't want to answer

12 If no, what was the reason?

- Not allowed by the school
- Child care responsibilities
- Financial situation
- Other reasons, please specify.....

13 What is your relationship to the father of your child?

- Husband
- Boyfriend
- I am not in a relationship
- Family member
- Others, please specify.....

14 How old is the father of your child?

- .....
- I don't know
- I don't want to answer

**Section II. Use of MCH/SRH services**

15 During your pregnancy, how many ANC visits did you have?

- 1
- 2
- 3
- 4

16 If less than four, what was the reason?

- I found out about the pregnancy late
- I could not afford it
- The distance to the Health Center was long
- I felt ashamed to be seen in public
- The health care workers treated me badly
- Other, please specify.....

17 Were any complications detected during your pregnancy?

- Yes
- No

18 Were you referred to a secondary hospital for treatment of these complications?

- Yes
- No

19 Did you deliver your baby in a health facility?

- Yes
- No
- Don't know
- I don't want to answer

20 If no, why not?

- The cost was high
- The distance was long
- I felt ashamed
- Other reasons, please specify.....

21 Did you experience any complications during delivery?

- Yes
- No

22 If yes, did the health center provide emergency care for these complications?

- Yes
- No

23 If yes, were you taken to a secondary hospital for emergency care?

- Yes
- No

24 Did you have a post-natal checkup after the birth?

- Yes
- No

25 If yes, when was the post-natal checkup done?

- 2 weeks
- 4 weeks
- 6 weeks
- 8 weeks
- Other, please specify.....

26 Did you have a postnatal checkup for your infant?

- Yes
- No
- Don't know
- I don't want to answer

27 If yes, when was the post-natal checkup done?

- 3-5 days after birth
- At 1 month
- At 2 month
- At 4 month
- At 5 month and above
- Other, please specify.....

28 Did you experience any problems after your delivery?

- Yes
- No

29 If yes, did you receive a referral to a secondary hospital?

- Yes
- No

30 How did you experience the care you were given from the health workers during your pregnancy and childbirth?

- The health workers treated me with care and respect
- The health workers gave me the necessary attention but nothing more
- The care given was inadequate
- I don't want to answer

30 Did you adopt a FP method after delivery?

- Yes
- No
- I don't know
- I don't want to answer

31 If yes, which FP method did you or your partner use?

- Cycle bead
- Standard Days Method
- Lactational Amenorrhea Method
- Injectable
- Pills
- Condoms
- IUD
- Implant
- Rhythm
- Withdrawal (coitus interruptus)
- Others, please specify.....

32 If no, what was the reason why you did not use any FP method?

- Fear of side effects
- Cost
- Opposition from partner
- I wanted another child

- I was not offered any method
- Others, please specify.....

33 Are you currently using FP?

- Yes
- No

34 How long would you like to wait from now before the birth of (another) child?

- I don't want another child
- I don't know
- I don't want to answer
- Less than 2 years
- After 2 years
- Others, please specify.....

35 If you want to delay but is not using FP, what is the reason?

- I do not know how to get it
- Partner opposition
- The cost is high
- I am afraid of side effects
- Others, please specify.....

36 Did you practice exclusive breastfeeding up to 6 months? (*Data collector has to explain carefully that exclusive breastfeeding refers to breastmilk only: no other foods, no liquids, no water, etc*)

- Yes
- No
- I don't know
- I don't want to answer

37 If no, why not?

- I did not know it was important
- I did not produce enough breastmilk
- I preferred formula
- I was taught that it is good to give water/liquids/other foods
- I had to work
- I go to school
- Other reasons, please specify.....

38 Did you experience any violence or discrimination during your pregnancy? *Tick all that apply.*

- Yes, violence
- Yes, discrimination
- No

39 If yes, where did it occur? *Tick all that apply.*

- At home
- At school
- In the community

## **Annex II: FOCUS GROUP DISCUSSION GUIDE**

District:

Date of FGD:

Number of participants:

Age of participants:

1. Can you tell us about your family/the household you live in? (probes; composition, livelihoods, economic status)
2. Can you tell us a bit about the community you live in?
3. Can you tell us about what happened when you became pregnant? (Probes; What was the relationship with the father of the child? Was there any violence involved? Did you know how a pregnancy occurs? Had you ever used any SRH services? Were you using any form of protection with your partner?)
4. How did your family react to the pregnancy? How about other people in the community, your friends, neighbors, etc.?
5. Did you experience any violence during your pregnancy or after?
6. During your pregnancy and when you gave birth, how did you experience the health care services you were given?
7. What kind of services did you use? (pre- , intra- and post- partum – probe for ANC, post-natal care, family planning)
8. What was your experience of health care workers' attitudes towards you? (Was it respectful, did you feel that they cared about you and your child?)
9. How did having a child affect or change your life? (Probes; education, livelihoods, family, relationships, friends, aspirations for the future etc.)
10. What are the biggest challenges you are facing as a young mother? (Probes; education, poverty, stigma, family and relationships, etc.)
11. What would be the best way of supporting you and other girls in the same situation? (Probes; In the family, the community, or other ways)

### Annex III: KEY INFORMANT INTERVIEW GUIDE

Date:

District:

Informant no.:

Age:

Occupation:

3. Can you tell us about the community you live in?
4. What is your role in this community?
5. In what ways do you think teenage pregnancies are affecting young girls in this area?  
*(Probes; Are they common? What are the challenges the girls face? How does it affect their children? Their families?)*
6. What kinds of services are provided to young girls who get pregnant? *(Probes; Health services, support to continue education, vocational training, social support, community services, or others)*
7. How could these services be improved?
8. In your opinion, what would be the best way of supporting young mothers and their children/families?
9. Who are the most important stakeholders to involve in the community? How best to involve them?