COLLEGE OF ARTS AND SOCIAL SCIENCES (CASS)

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MASTERS IN PEACE STUDIES AND CONFLICTS TRANSFORMATION
MUSANZE CAMPUS

THE EFFECTIVENESS OF SEXUAL REPRODUCTIVE HEALTH CAMPAIGNS IN COMBATING TEENAGE PREGNANCY IN RWANDA. A CASE STUDY OF KICUKIRO DISTRICT

A Research Project submitted in partial fulfillment of the Requirement for the award of a Master's Degree of Arts in Peace Studies and Conflicts Transformation.

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DECLARATION OF ORIGINALITY

I, **Angelique UWAMARIYA** hereby declare that the content in this research entitled**" The Effectiveness of Sexual Reproductive Health Campaign in Combating teenage pregnancy: Case Study of Kicukiro District''** is an original work and has not been submitted in any form for any degree to any University. Duly referenced acknowledgements were made to any other information from other sources.

Signature…….

Angelique UWAMARIYA

Date of submission……. /……/…….

CERTIFICATION

This is to certify that this thesis entitled "*The effectiveness of sexual reproductive Health Campaigns in Combating Teenage Pregnancy in KICUKIRO District*" is an original work carried out by Angelique UWAMARIYA, under my supervision and guidance and is hereby accepted and recommended for Approval for the Award of the Master's Degree of Arts in Peace Studies and Conflicts Transformation by University of Rwanda.

Dr Celestin HATEGEKIMANA

Supervisor

Signature

DEDICATION

This thesis is dedicated to my Parents, Mr KAREKEZI Abraham and My Mother Yankulije Agathe (RIP), who helped me become the person I am.

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LIST OF ABBREVIATIONS AND ACCRONYMS

SRH: Sexual and reproductive health

WHO: World Health Organization

UNFPA: United Nations Population Fund

ECOSOC: Economic and Social Council

ARC: Actions for the Rights of Children

USA: United States of America

RDHS: Rwanda Demographic and Health Survey

YWCA: Young Women Christian Association

UR: University of Rwanda

ICPD: The International Conference on Population and Development

MoH: Ministry of Health

DFID: Department for International Development

ASRHR: Anti-Sexual Reproductive Health Rights

ABSTRACT

Sexual reproductive Health (SRH) education is recognized in combating teenage pregnancy. The general objective was to explore the role played by community campaigns in addressing SRH in Kicukiro District, City of Kigali. The specific objectives of the study were: (1) to investigate the root causes of high rate of teenage pregnancy in Kicukiro District, (2) to explore the way SRH campaign responds to the teenage pregnancy issue in Kicukiro District, and (3) to identify the challenges met during SRH campaign in Kicukiro and propose the way forward. To achieve these objectives, the study adopted a qualitative research design. The target population was composed of 75 people (50 victims of teenage pregnancy, 5 key informants who are local leaders, 5 key informants from concerned ministries, 15 parents of the victims and other parents who are not necessarily parents of the victims); this sample was selected from the total population of 300 people. Data was collected using interviews (in-depth interviews and key informant interviews) and Focus group discussions (FGDs). FGDs and in-depths and key informant interviews have been face to face with respect to COVID19 measures and thematic analysis was performed on transcribed discussions. The findings show that Kicukiro District made a good step to organized campaign to address SRH which is one of the main root causes of teenage pregnancy. In other words, measures to address this phenomenon include access to comprehensive sexuality education for teenagers about SRH as a preventive measure. The findings also highlighted five components that are necessary for good sexual and reproductive health: ensuring contraceptive choice and safety and infertility services, improving maternal and newborn health, reducing sexually transmitted infections, including HIV, and other reproductive morbidities, eliminating unsafe abortion and providing post-abortion care and promoting healthy sexuality, including adolescent health, and reducing harmful practices, but above all, organizing community campaign about SRH. This study recommends to adopt a holistic and multi-sectorial approach to address teenage pregnancy in Kicukiro and else.

Key words: SRH, community campaigns, teenage pregnancy, Ministry of Health, World Health Organization (WHO)

CHAPTER ONE

INTRIODUCTION TOI THE STUDY

1.0 INTRODUCTION

This chapter is the introduction to the study. It discusses the background of the study on "*The effectiveness of sexual reproductive Health Campaigns in Combating Teenage Pregnancy in KICUKIRO District*". This chapter shows the gap in the study and proposes the objectives fill in the gap and the questions to be answered to reach these objectives. This chapter also mentions the scope, research motivation, and the structure of the study.

1.1. BACKGROUND OF THE STUDY

The context of Rwanda

This study was conducted in Rwanda; whose surface is 26,338 km^2 on the eastern should of lake Kivu-Tanganyika rift in Africa. It lies between 1^o 4 and 2^o51 south latitude and 28^o 53 and 30^o 53 east longitude. Rwanda is made of five provinces of Rwanda which are also divided into 30 districts. Each district is in turn divided into sectors , which are in turn divided into *cells*, which are in turn divided into *villages*. Teenage pregnancy in Rwanda has been a big problem among the youth, and the situation has been fuelled by the situation of COVID19 where people were supposed to be in lockdowns. Some district faced the challenge more than others, such as Gatsibo in the Eastern province and Kicukiro in the City of Kigali.

The table below shows more details about Rwanda, districts and more demographics:

Province	Districts	Area (km^2)	Population (2012 census)	Density (per km^2)
City of Kigali	Nyarugenge, Gasabo and **Kicukiro**	730	1,132,686	1,551.62
Southern	Gisagara, Huye, Nyaruguru, Kamonyi, Nyamagabe, Ruhango, Nyanza and Kamonyi	5,963	2,589,975	434.34
Western	Karongi, Nyabihu, Rubavu and Rutsiro, Ngororero, Nyamasheke and Rusizi, Kibuye	5,883	2,471,239	420.06
Northern	Burere, Gicumbi, Rulindo, Musanze and Gakenke	3,276	1,726,370	526.97
Eastern	Rwamagana, Kayonza, Ngoma, Bugesera, Gtsibo, Kirehe, Nyagatare	9,458	2,595,703	274.44

Source: Google map 2020

Figure 1: The District of Kicukiro is located in the City of Kigali as shown of this map:

Source: Google map 2020

The Kicukiro District occupies a surface of 166.7 km^2 and is made up of ten (10) administrative sectors (**Kicukiro, Kagarama, Niboye, Gatenga, Gikondo, Gahanga, Kanombe, Nyarugunga, Kigarama, Masaka**), 41cells and 333 Administrative villages.My research study will focused in Gikondo and Gahanga sectors ,the last one is in remote area where sexual workers are flourishing and other is in urban area .

It can be an exciting, stressful, frightening or difficult time. It is increasingly recognized that support and intervention to ensure good sexual and reproductive health for young people can have a life-long beneficial effect: decisions or events relating to sexual behavior and activity that occur between the ages of 10–24 can be a major factor in the direction that a young person's life will take. A sexually active 13-year-old girl, for example, regardless of whether her sexual activity is from an early marriage, child prostitution or curiosity, will probably never complete her education. She will be more at risk from other reproductive health problems and, following from that, she will be more likely to experience social and psychological problems. (United Nations Population Fund, 2014; WHO, 2004).

For instance, in the United States of America (USA), according to Meynard's Estimates in 2001 cited by Isabel V. Sawhill (2021), the government spends around $ 3,200 per year on each teen mother. The cost of teenage pregnancy in developing countries is unknown because there is no research available. However, the consequences are very high. Joao Pedro Azevedo et al. (2012: 20) pointed out that there are consequences on the mother and other household members, which creates a burden for the teen mother. According to Agampodi SB et al. (2008: 1-8), sexual and reproductive health services in developing countries have been hindered by problems.

Concern with healthy and responsible sexuality has in the past decade grown in family planning programmes, as well as in other health and social activities, primarily for two reasons: the increase of adolescent sexuality, pregnancy and abortion, and the wide-spread growth in sexually transmitted infections, including the Human Immunodeficiency Virus (HIV) causing AIDS. Annually, more than 333 million new cases of STIs are estimated to occur, making them one of the most common infectious diseases around the world, particularly in the 15-49 age group. Estimates suggest that more than half of the people living with HIV/AIDS were infected before they were 25 years of age. Premarital sexual experience is becoming more common among young people in developing countries. As countries have become more urban and economically developed, the age at marriage has risen, and young people's sexual attitude and behaviour before marriage have been changing. For refugee or displaced young people, these issues are likely to affect them even more acutely than when they are living in settled situations. Because adolescents typically begin sexual relations without contemplating the consequences and without accurate information and protection, many face serious and even dangerous consequences, including unwanted pregnancies, abortions, Sexually Transmitted Infections (STIs) and HIV/AIDS.

Sexual and reproductive health (SRH) is a universal challenge and is a human rights matter. SRH is linked to social, mental and physical wellbeing in all aspects related to sexuality and the reproductive system. In the views of Starrs et al. (2018), every individual has a full right to decide on his/her body and access services that support that right. Everyone has the right to choose their SRH, which suggests that people should be capable to have a substantial and safe sex life, the

ability to reproduce, and the freedom to take decision if, when, and how often to do so. (United Nations Population Fund, 2014; WHO, 2004).

Sexual and reproductive health (SRH) is an act that regards someone individually, so people may have struggles to find or ask for precise information about it. Information from WHO highlighted that this may also help in explaining why these issues are still not resolved agreeably, and services are inadequate, fragmented, and unfriendly in some countries around the world. (WHO, 10 October 2021). WHO (2016) stipulated that everyone is sexual a being throughout the whole live. The aim of sexual health care should be to strengthen life and personal relationships, not merely counseling and care related to procreation or sexually transmitted infections. Moreover, SRH suggests that people can have a responsible, sustaining, and safe sex life and they have children and the freedom on decision, when, and how often to do so. SRH has been a human right concern since the International Conference on Population and Development held in Cairo in 1994 (ICPD25: 1994). Given how challenging was sexual and reproductive health, the Beijing Conference, 1995 enhanced factors that present problems to the provision of reproductive health services, particularly for young people (UN, 1994: 30 paragraph 7.2):

- Insufficient levels of skills about human sexuality;
- Unsuitable or poor-quality reproductive health information and services;
- The prevalence of high-risk sexual behavior;
- Biased social practices;
- Critical attitudes towards women and girls;
- Different women and girls have limited power over their sexual and reproductive lives.

A baseline on the use of SRH worldwide is alarming. Indeed, only 55 percent of married or in-union women aged 15 to 49 can decide themselves with regard to sexual and reproductive health and rights, based on data from 57 countries. (UNFPA, 2018). Furthermore, there are significant disparities among regions from the Middle Africa, Western Africa, Europe, South-eastern Asia, to Latin America and the Caribbean. (UNFPA, 2018). Still on the matter of women deciding on sexual and reproductive health rights, UNFPA (2018: 4) has mentioned different loopholes. As a

matter of fact, in Southern Africa, 92 percent of married or in-union women can take decision on their health care, and 75 percent aren't interested to sex. By contrast, in Middle Africa, 50 percent of women are able to decide about their health care, and close to 80 percent aren't interested to sex. This is the same in Eastern Asia and South-eastern Asia, Latin America and the Caribbean, over 85 percent of women can make decisions. (UNFPA**,** 2018: 7). Additionally, the extent to which women make decisions with regard to sexual and reproductive health care greatly varies throughout different countries. Ecuador has the highest level, at 87 percent, thereafter the Philippines and Ukraine, where 81 percent of married or in-union women can make decisions on sexual and reproductive health care. Mali, Niger, and Senegal are among the countries with the lowest levels, with less than 10 percent of married or in-union women participating in sexual and reproductive health care decisions. (UNFPA, ibid.).

It has been noted that Sub-Saharan Africa has the highest percentage (32%) of young people aged 10 – 24 years. Policies that do not allow or expressly guarantee youths and adolescents access to sexual and reproductive health and rights is potential to leading to unplanned pregnancies, growing STIs and HIV, and unsafe abortions. (ECOSOC, 2019). The figures below on sexual and reproductive health care are alarming, and something has to be done for future generations: Indeed, ECOSOC has noted about 31% of females between the ages of 20 and 24 in the African region were married before age 18. The highest rates of early marriage were respectively in the following countries: Niger (76%), Central African Republic (68%), Chad (67%), Mali (54%), and South Sudan (52%). Furthermore, the African region has the highest number of births to women aged 15-19 per 1000 women in that age group compared to other areas worldwide. The global rate is 44 births per 1000 adolescent females. (ECOSOC, 2017).

The existing literature on Rwanda showed that accessibility to SRH services for adolescents is still low. Family influences, socio-cultural stigma, and religious obstacles burden adolescents' SRH services utilization. (Ndayishimiye et al. 2019). Furthermore, the Catholic Church's position on the family planning and reproductive issue is a big handicap to the SRH campaigns. Indeed, according to the encyclical Humanae Vitae, sex is primarily intended to produce offspring but is welcome in marriage only. This document says that the sexual act must remain intact for

procreation. The encyclical condemns other methods aimed at preventing or artificially limiting reproduction. (Paul VI (1968), Humanae Vitae).

It is noted that Humane Vitae is applied worldwide in the Catholic Church. In this regard, an international conference was held in Kigali on 9th and 10th February 2019 to celebrate the 50th anniversary of this encyclical. The aim of the conference was to reinforce the paramount importance of the prophetical teachings on marital life in Humanae Vitae. The organizers had intention to propose pastoral reflection and initiatives for young people and families to promote the extraordinary value of true conjugal love, responsible parenthood, and natural family planning. Accessibility to SRH services is not welcome in Catholic church-run health facilities. According to the New Times (4 September 2016), the Catholic Church in Rwanda has about 115 health centers and nine hospitals. According to Bishop P Rukamba, catholic church-run health facilities in the country were no longer offering artificial contraceptives because it is against the Roman Church doctrine. As of 2021, in Kicukiro District, there were 1 Hospital, 10 Health Centres (4 of them belong to the Catholic Church while 2 and 4 belong to Zion Temple and Bethsaida, respectively), and 11 Health Posts. In view of the above, it is noted that access to SRH information and SRH-related services is underprovided because most of the health facilities belong to the churches whose stance is not favoring the use of SRH services.

Even though there is a lot to do to provide SRH education, Rwanda should be proud of its women's level in decision-making. Indeed, Rwanda women's decision-making on SRH has remarkably grown. Data available in 2018 shows that 84% could decide on their health, 98% could determine their contraceptive use, 83% could say no to sex, and 70% could make decisions on sexual and reproductive health and right. (UNFPA, 2018: 5)

The negative effects of being hesitant in providing the teen girls with acceptable sexual and reproductive health services led to early and unwanted pregnancies and this will always affect people's lives during adolescence. (ARC2009:7). They are undergoing some biological changes that need special attention. The government and its partners have invested heavily to reduce these risks. ARC proposed, among other things, to provide young people with effective sexual health

education and reproductive health care opportunities that will contribute significantly to their safety. (Ndayishimiye et al. 2019).

Accessibility to effective SRH education and services is highly encouraged to prevent early pregnancies among adolescents. Pregnancy among adolescents is a common public health problem in industrialized, middle or low-income countries (WHO, 1995). Indeed, according to Darroch (2001), 9% of adolescents between the ages of 15 to 19 years become pregnant each year in the US. According to the World Health Statistics 2014, the average global birth rate among 15–19-year-olds is 49 per 1000 girls, whereas country rates range from 1 to 299 births per 1000 girls. Rates were highest in Sub-Saharan Africa. (Sedgh G et al. 2015). Sedgh et al. (2015) pointed out that in the 1960s and 1970s, both society and health authorities increasingly viewed the growing number of adolescent pregnancies as a problem.

In areas like the Middle East and North Africa, the regional average rate of births per 1000 females 15–19 years of age is 56. (Singh, 1998). Europe is the only region where the average rate of births by 1000 females is lower because it accounts for 25. (Singh, 1998). Coming to Rwanda, the increase in teenage pregnancy rates in Rwanda in recent years is troublesome. The data from NISR indicate from 2007/2008 to 2014/2015, adolescent pregnancy increased from 5.7% to 7.2% of the teen girls countrywide, and from 14% to nearly 21% among young girls aged 19 (NISR, 2009; 2012; 2015).

Furthermore, the Actions for the Rights of Children (ARC) argued that this growing awareness of sexuality can have an acute effect on how young people conduct themselves. Men and women should have access to the safe, practical, affordable, and acceptable methods of fertility regulation of their choice and to appropriate health care services that will enable women to go safely through pregnancy and childbirth. Additionally, ARC, citing the Department of Child and Adolescent Health Development of the United Nations, recognized that today's young people are more at risk of reproductive health than some of their predecessors (ARC2009:7). Indeed, there are plentiful reasons behind that. They include but are not limited to increasing urbanization, the breakdown of traditional social and economic structures, and the increased mobility of the world's population.

Sexual and reproductive health services are paramount in sustainable development. According to the World Health organization, achieving universal access to sexual and reproductive health and rights (SRHR) is pivotal to achieving Sustainable Development Goals (WHO, 2017). The same cases happened in many other different developing countries. These authors confirmed, and we agree with them on the reasons behind this scourge. Indeed, there has been a gradual shift away from extended family structures and toward nuclear families in many countries. With this change in family structure and way of living, the role of members in an extended family in educating and acting as role models for young people in sexual behaviors has disappeared.

Additionally, Senanayake and Ladjali (1994) reported the most affected African countries; cultural aspect played a big role. Some scholars like Chemuru and Srinivas (2015) supported this argument pointing out that family and cultural norms such as early marriage in developing countries have also accounted for high teenage pregnancy in Africa. Sharma et al. (2002) also noted that early marriage is culturally acceptable in many developing countries. In Rwanda, for instance, while the minimum age for legal marriage is 21years, early cohabitation remains common (Coast et al. 2019). Parents may also choose to informally marry their daughters off early to access the 'bride price' and avoid paying an increased dowry (Stavropoulos and Gupta-Archer, 2017).

Furthermore, Senanayake and Ladjali (1994) made it clear that one in five adolescent females give birth each year in some sub-Saharan African countries. Hence, almost all females are likely to have had a child by age 20. They have also pointed out that in some parts of Latin America, 30– 40% of all adolescent's experience motherhood before the age of 18. Recent studies stressed that girls from wealthier families might be exposed to sexual risky information that comes with access to the internet (Mollborn, 2017). The vulnerability of the poorest may be related to sexually-linked financial inducements to supply what parents cannot (Okigbo and Speizer, 2015). Kirby et al. (2007) noted the likelihood of teen girls being pregnant when their parents were separate

In Rwanda, for example, despite the government's interventions through improved sex education and teenage mentoring mainly in primary and high schools, the problem is still there. (RMOH,

2018: 1-106). Additionally, Rwanda enacted laws and put in place policies that prioritized access to Anti-Sexual and Reproductive Health Rights (ASRHR), broadened access to legal abortions, and implemented a six-year strategy focused on ASRHR (MOH, 2018) with other interventions that may help to curb this scourge.

In this regard, the government updated defilement laws to punish men who impregnate young girls. This Law Nº68/2018 of 30/08/2018 determining offences and penalties in general, defines sexual intercourse with teens as sexual violence against young people and assigns severe punishment. Indeed, art 133 of the law no 68/2018 determining offenses and penalties in general states that, upon conviction, they are liable to imprisonment for a term of not less than twenty (20) years and not more than twenty-five (25) years. If child defilement is committed on a child under fourteen (14) years, the penalty is life imprisonment that cannot be mitigated by any circumstances (Official Gazette No Special of 27/09/2018)

Art 125 of the law no 68/2018 determining offenses and penalties in general also exempts from criminal liability for abortion when (Official Gazette No Special of 27/09/2018):

- the pregnant person is a child;
- the person having an abortion had become pregnant as a result of rape;
- the person having an abortion had become pregnant after being subjected to a forced marriage;
- the person having an abortion had become pregnant as a result of incest up to the second degree;
- the pregnancy puts the health of the pregnant person or the fetus at risk.

In Rwanda, studies show a rapid increase over the past two decades. Despite the political achievements of women's empowerment and efforts to curtail child sexual abuse teenage pregnancies remain unacceptably high. (Odejimi et al.2016). It has been noted that over the last decade, the Rwandan Government has been credited for promoting gender equality and ASRHR (Coast et al. 2019; Isimbi et al..2017).

Factors contributing to teenage pregnancy are many and can range from individual, traditional, socio-cultural, and religious. They include but are not limited to: low socio economic status (Bonelli C, et al. 2005); limited education, and early sexual activities (Vikat A, et al. 2002). It has been observed that adolescent girls from households that live in poverty were involved in sexual relationships in exchange for gifts such as money, clothes, and other goods (UNFPA, 2013). Furthermore, evidence indicates that reduced access to contraceptives and barriers to reproductive health services among adolescents and young adults was associated with teenage pregnancy in many African countries, including Rwanda. (Kaphagawani and Kalipeni, 2017).

We should also add to the above factors that teens lack access to education opportunities, sex education, and information regarding contraceptives, which predisposed them to pregnancies (Were, 2007). Though much has been done in Rwanda, there is still an increased number of teenage pregnancies. Indeed, the recent contribution from various scholars confirmed the high increase in teenage pregnancy in Rwanda. According to Gage Policy Brief (2020:1), citing Hakizimana et al. (2018) Rwanda has seen an increase in reported adolescent pregnancy rates from 4.1% in 2005 to 7.5%2 in 2015. In 2016, the number of teenage births recorded was 17,849; in 2017, it reduced to 17,337 teenage births, but in 2018, it increased to 19,832 and later 23,628 in 2019. (New Times, 24 May 2021).

From January to August 2020, teen pregnancies increased to 15,696, which translates to an average of 1,962 a month. Based on this, an estimated 23,544 children were born to teen mothers in 2019. Broken down by leading districts in 2018, Nyagatare registered 1,465 teen pregnancies, Gatsibo 1,452, Gasabo 1,064, and Kirehe 1,055. (New Times, 16 February 2021). New Times also quoted the Director-General in charge of Family Planning and Child Protections in MIGERPROFE as saying that a total of 19,701 girls from all over the country gave birth between January and December 2020 (New Times, 24 May 2021)

Though there were initial fears that the confinement brought about by the Covid-19 pandemic could cause a spike in these figures, so far, the number of girls that gave birth in 2020 had reduced by 3,927, said the Director-General in Charge of Family Planning and child protection in

MIGERPROFE. It was at a ceremony to unveil the United Nations Population Fund (UNFPA)'s 2021 Flagship State of the World Population Report. (New Times, 24 May 2021).

We should keep in mind that teenage pregnancies affect the mother, the child, and the country as a whole. It is a health problem and, at the same time, a security concern to address at all costs.

1.2. STATEMENT OF THE PROBLEM

The rate of Teenage pregnancy is worrisome. This problem was fueled by the situation of COVID19, the period where teenage pregnancy raised at a high level. DFID pointed out that poor people, especially women and young people, face huge social and economic barriers to sexual and reproductive health. One hundred twenty million couples do not have access to the family planning services and contraception they need. Every year, 529,000 women die from complications of pregnancy and childbirth, and 3 million children die in the first week of life. (DFID, 2004). Sexual and reproductive health if not dealt with adequately, may lead to teenage pregnancies, and the cost is very high for the government, the society, and the victims.

Teenage pregnancies are increasing in Rwanda through the government's interventions to curb them. According to Rwanda Demographic and Health Survey (RDHS, 2019-2020), the proportion of teenagers who have begun childbearing rises rapidly with age, from less than 1% at age 15 to 15% at age 19. Teenagers with no education tend to start childbearing earlier than other teenagers. Teenagers in the eastern province are more likely to start childbearing earlier than their counterparts (RGHS, 2019-2020: 14). Coast et al. (2019) argued that adolescents' needs for ASRHR information and products are primarily unmet. Indeed, there are many reasons behind this scourge. They range from limited availability of specialized trained health care providers, cultural mores and myths, religious beliefs, and peer pressure to name but a few. In Rwanda, for instance, the catholic church's influence is an obstacle to the use of ASRH. According to the Encyclical Letter Humanae Vitae of the Supreme Pontiff Paul VI, human procreation should be guided by certain doctrinal principles: the demands of married love or responsible parenthood. Beyond these two principles, any attempt to justify artificial birth control methods is unacceptable. (Encyclical Letter Humanae Vitae: 7)

Researchers noted the need to avail SRH information to all the stakeholders, including teens who do not attend or dropped out from the school, parents, media, and religious leaders, to name but a few. Although political will, laws, policies, and strategies plans are in place to tackle the teenage pregnancy issue in Rwanda, there is a lot to do in awareness campaigns. Access to SRH information and services to the teens is still needed all over the country and in Kicukiro District in particular. The unpublished data collected from Kicukiro District show that 132 girls got pregnant during the period under review (RIB, 2020). Finally, the newly elected women representatives in Kicukiro District highlighted teenage pregnancy as a recurring issue and a big burden to the country and therefore recommended that community campaigns be conducted at the community level. (New Times, 29 December 2021). Furthermore, data from Kicukiro District tells us that, in collaboration with the Ministry of Health and RBC, the Young Women Christian Association (YWCA) is implementing an SRH project in Kicukiro. This project is called Dreams, and 14455 young girls and young women receive information about SRH once a week. We believe that the number attending the course is low if we consider the number of early pregnancies in the Kicukiro District. We should also note the absence of men and parents in this endeavor. The target groups should be extended to those categories if we want to succeed. In line with the above, this study will discuss the effectiveness of the sexual reproductive health campaigns in combating teenage pregnancies.

1.3. RESEARCH OBJECTIVES

The general objective of this study is to investigate the extent to which the SRH campaign can address the teenage pregnancy situation.

This study will specifically deal with the following objectives:

- To investigate the root causes of the high rate of the teenage pregnancy in the Kicukiro district
- To explore the way, the SRH campaign responds to the teenage pregnancy issue in Kicukiro District.
- To identify the challenges met during the SRH campaign in Kicukiro and propose the way forward

1.4. RESEARCH QUESTIONS

For this study, the research will answer the following questions:

- What are the root causes of high rate of teenage pregnancy in the Kicukiro district?
- What are the ways the SRH campaign responds to the teenage pregnancy issue in Kicukiro District?
- What are the challenges met during the SRH campaign in Kicukiro and what can be proposed as a way forward?

1.5. THE SCOPE OF THE STUDY

This study will cover 2019 to 2020 and will focus on Kicukiro District. We will conduct our research in Gikondo and Gahanga sectors. The choice of these two sectors is motivated by the fact that the former is an area where sex workers are flourishing, and the latter is a remote area. After that, we will compare recommendations generated to reduce the rate of teenage pregnancy in the Kicukiro District.

1.6. SIGNIFICANCE OF THE STUDY

This study is very significant for the following reasons:
The researcher will contribute to the scientific research by addressing the identified gaps in the literature review. The University of Rwanda (UR) as a learning institution will also benefit from this research and consolidate the learning process in its different Colleges. Policymakers will finally use the recommendations generated from this study and curb the rate of teenage pregnancies in Rwanda in general and Kicukiro in particular. The researcher will also conduct interviews with selected people who have a broad knowledge of teenage pregnancy. More importantly, victims will be given more time to discuss what happened to them. I will finally use questionnaires to select as much data as possible.

1.7. STRUCTURE OF THE STUDY

This study is made of five chapters. Chapter one is the Introduction to the study Chapter two is the review of the existing literature related to the topic and research gap is shown in order to justify the usefulness of this research. Chapter Three is the research Methodology. Chapter four is data presentation and discussion. Chapter five is the summary of findings and general conclusion.

CHAPTER TWO
LITERATURE REVIEW
2.0. INTRODUCTION

This chapter discusses the key concepts about sexual and reproductive health and does a literature review to find the gap in the existing literature. It also discusses the theoretical framework and the conceptual framework**.**

2.1 Global overview

After the 1994 ACPD in Cairo, many solutions have been globally proposed to reduce the scourge of teenage pregnancies. They include but are not limited to community-based programs and Media campaigns. They were proven to be among the best in curbing teenage pregnancy. Indeed, according to statistics, teen girls are exposed to social media for at least 38 hours a week. (Isabel V. Sawhill: 2021). Many countries have adhered to the proposed guidelines and Rwanda's interventions have laid down the foundations to curb the scourge of teenage pregnancies. Indeed, Sexual and reproductive health campaigns in Primary and secondary schools have been conducted, and SRH services availed. It has, however, been noted that only a small number of the beneficiaries accessed the services, and unwanted teenage pregnancies are still available (NISR, 2015:640).

Sexual and reproduction health is a global phenomenon from Asia, to Europe, America and Africa. In the European Union countries, sexual and reproductive health is a very personal issue and concerns everyone, young or old, male or female for a large part of their lives. This issue begins to affect people's lives at adolescence when they are aware that they are starting to change from being children and are growing towards adulthood. Because this is such a major life change, this growing awareness of sexuality can have an acute effect on the way that young people conduct themselves and their lives. 2.2.2 Sexual and Reproductive Health

Starrs, Ann et al. (2018:1642-92) defined sexual and reproductive health as a state of physical, emotional, mental, and social wellbeing with all aspects of sexuality and reproduction, not merely the absence of disease dysfunction or infirmity. This definition of reproductive health, which was adopted at the ICPD held in Cairo in 1994, went beyond earlier definitions, recognizing the

importance of women's empowerment and human rights and links to other aspects of health and development. The concept of sexual and reproductive health includes family planning and maternal and newborn healthcare, prevention, diagnosis, and treatment of sexually transmitted infections, issues such as eliminating gender-based violence, harmful practices, coercion or abuse, and gender inequalities integrally related. The International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, and its resulting Programme of Action recognized that reproductive health, including sexual health and reproductive rights, as well as gender equality and women's empowerment, are critical to improving the quality of life for everyone. (WHO, 2016). This issue requires addressing all means, including educating all people involved. Indeed, access to comprehensive sexuality education is essential. According to the UN Millennium Project Report, the World Health Organization (WHO: 2004) outlined five components that are necessary for good sexual and reproductive health:

- Ensuring contraceptive choice and safety and infertility services
- Improving maternal and newborn health
- Reducing sexually transmitted infections, including HIV, and other reproductive morbidities
- Eliminating unsafe abortion and providing post-abortion care
- Promoting healthy sexuality, including adolescent health, and reducing harmful practices.

2.1.2 Teenage pregnancy

Teenage pregnancy sometimes used as adolescent pregnancy is defined as pregnancy under the age of 20 years. It is a problem in both developed and developing countries. According to Seetesh Ghose and Lopamudra B John (2017), many adolescents are neither physically nor psychologically ready for pregnancy or childbirth. This reproductive event makes them more vulnerable to complications resulting in devastating health consequences. They include but are not limited to early dropout from school and health problems that jeopardize their income-earning potential (Seetesh Ghose and Lopamudra B John, 2017).

Available statistics indicate that approximately 16 million girls aged 15 to 19 years and two million girls under 15 take place in developing countries. Several factors contribute to the increase of the risks associated with teenage pregnancy. They include but are not limited to residing in disorganized/dangerous neighborhoods, living with a single parent, having older sexually active siblings or pregnant/parenting teenage sisters, and being victims of sexual abuse.
Miller BC et al. (2001) noted that parent/child closeness or connectedness, parental supervision or regulation of children's activities, and parents' value against teen intercourse (or unprotected intercourse) decrease the risk of adolescent pregnancy.

Since the 1994 ICPD held in Cairo, countries have invested in Sexual and Reproductive Health Services, and today they still have a lot to do to meet what was expected from that conference.
In Rwanda, for instance, the government set goals to be achieved by 2024. Indeed, every Rwandan citizen of reproductive age fully exercise their sexual reproductive health and have access to the services of their choice, improving sexual and reproductive health and enabling an overall increase in contraceptive prevalence by 2024(National Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan 2018-2024)

Rwanda is among the signatories of the 1994 International Conference for Population and Development (ICPD), where 179 countries had a remarkable consensus that individual human rights and dignity, including the equal rights of women and girls and universal access to SRH and rights, are necessary preconditions for sustainable development. (FP/ASRH SP, 2018).
Since then, laws, policies, and other strategic documents have been in place to ease the implementation of SRH among teens. Indeed, in 2016, Rwanda's parliament passed the Reproductive Health law. In article 3, it defines key components of reproductive health, also including a) "prevention of gender-based violence and care for victims thereof"; b) "raising awareness with the aim of attitudinal behavior change" (FP/ASRH SP, 2018)

For ASRH, evaluations globally of many life skills curricula have demonstrated improvements in teen pregnancy rates, girls' empowerment, and self-reported condom use. (Patton, 2014). Various ministries should be involved in this, and the MoH should lead. Evidence has also shown that the

most impactful ASRH programs include holistic, multi-sectoral packages of interventions based on a theory of change (Denno, 2015) (Chandra-Mouli V. e., 2015). These will require long-term investments in protective assets. it includes parents and other community members (The Republic of Rwanda, Ministry of Health, 2011). However, many adults in Rwanda support sexuality education for youth and would be willing to provide advice if they could overcome cultural difficulties in talking openly about SRH (the republic of Rwanda, Ministry of Health, 2011) (RDHS). Mass media campaigns and community sensitization are cited as effective in reaching these important gatekeepers.

The EU remains committed to playing a leading role for women's and girl's empowerment and promotes and protects sexual and reproductive health and rights. The EU approved a new Action Plan on Gender Equality and Women's Empowerment (GAP III). The Action Plan calls for accelerating progress, focusing on the key thematic areas of engagement, including sexual and reproductive health and rights**.** EU interventions can be seen at bilateral, regional and global levels. The EU-UN Spotlight Initiative is an excellent example of dynamic multilateral cooperation to deliver concrete results. The initiative represents the largest global effort to eliminate violence against women and girls**,** running in 26 countries across 6 regions, with a total funding of EUR 500 million. EUR 100 million of this initiative are specifically dedicated to sexual and reproductive health and rights**.**

In Asia, there are almost one billion young people aged between 10 and 24 years living in Asia and the Pacific, accounting for more than a quarter of the population in this region. These young people live in diverse socio-cultural and economic contexts, yet they share important challenges and opportunities related to their sexual and reproductive health. In all countries, increasing access to media, urbanization and globalization are contributing to changing sexual values, norms and behaviours of young people, often in conflict with the traditional, conservative socio-cultural attitudes towards premarital sex and gender norms. These factors contribute to significant barriers that limit young people's access to information and services that they need to make a healthy transition into adulthood. (Hull TH, Hasmi E, Widyantoro N, 2004)

A significant proportion of young people in the region are sexually active, and while for many the onset of sexual activity is associated with marriage, an increasing number are initiating sex before marriage. The available information indicates that youngest people are ill-prepared for this

transition, having insufficient knowledge and life-skills to negotiate safe and consensual relationships and facing considerable barriers to accessing services and commodities needed to avoid unsafe sex and its consequences. Additionally, a significant proportion of adolescent girls and young women report coerced sex and up to half have experienced sexual violence. Rates of violence are also high among young female sex workers, men who have sex with men, and young transgender people. (Maticka-Tyndale E, 2005)

2.1.3 Comparative Analysis

The USAID Bureau of Africa (2012) and it partners have identified three most successful countries in the use of modern contraceptive methods among married women and reproductive age. They include Rwanda, Malawi, and Ethiopia It has been noted that the increased demand in family planning has become a cultural since the ICPD held in Cairo in 1994. The key successes in Ethiopia family planning include:

- Personal commitment and leadership of the Minister of Health and Prime Minister
- Bringing services to the doorstep in the rural areas through the Health Extension Workers
- Improvements in infrastructure, especially health centers and health posts
- Improvements in health system quality, especially logistics and supervision
- Inclusion of the health partners and NGOs in the program
- A sense of pride, purpose, and optimism that Ethiopia is on its way to meeting the Millennium Development Goals

In Malawi, the following constitutes the key successes in family planning:

- Political Commitment to Family Planning Reflected in Core National Policies
- Financing the health sector: a sector-wide approach and decentralization
- Transforming the deliveries of family planning services
- Culture of acceptance for family planning
- Reaching youth with family planning
- Sustaining and building upon the achievements
- Ensuring contraceptive security
- Expanding use the long –acting and permanent methods

- Increasing equity in access to contraception to reduce the unmet needs for family planning

Rwanda has made and achieved a lot in the last decade. Indeed, the increase in the use of modern contraceptive methods from 4% in 2000, to 10% in 2005 and to 45% in 2010 has become a phenomenal success to be proud of. It has therefore been noted that the Rwandan fertility has been reduced from 6.1% to 4.6% in 2010.

2.2 Sexual and reproductive Health: A comparative analysis

The challenge of social and reproductive health is almost the same around the world, because development and technology which fuels the situation of the youth and sexuality is the same around the world. However, in addressing the challenge, countries differ according to their context and culture. The so-called developed countries use rights-cased approach and allow abortion for unwanted pregnancy. The equal and inalienable rights of all human beings provide the foundation for freedom, justice and peace in the world, according to the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948.Achieving equality and dignity of all also underpins the Programme of Action of the International Conference on Population and Development (ICPD), which guides our work. Prioritizing the application of human rights principles became a cornerstone of UN reform efforts initiated in 1997. UNFPA was one of the agencies that in 2003 adopted the UN Common Understanding on a Human-Rights-Based Approach (HRBA) to Development Cooperation, which clarifies how human rights standards and principles should be put into practice in programming. The human rights-based approach focuses on those who are most marginalized, excluded or discriminated against. This often requires an analysis of gender norms, different forms of discrimination and power imbalances to ensure that interventions reach the most marginalized segments of the population.

2.3 Sexual and reproductive Health: A legal framework a comparative analysis

According to the resolutions of UN Convention on the Rights of Persons with Disabilities, 20098, UN HRC 'Communication No. 1153/2003 (24 October 2005) & UN Committee on the Elimination of Discrimination against Women (30 January 1992):

The term ‘reproductive rights’ has not yet been defined by any international human rights convention. However, Art. 23 (1) (b) International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities entails the right to reproductive health and education and, on a regional level, Art. 14 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (‘Maputo Protocol’) expressly articulates women's reproductive rights as human rights (Disabled People, Non-Discrimination of; Women, Rights of, International Protection).

Nonetheless, the content and scope of reproductive rights remains controversial. There are two positions on this matter. Scholars supporting a narrow position affirm that reproductive rights rest only on the recognition of reproductive choice, and argue that binding reproductive rights are limited to Art. 16 (1) (e) Convention on the Elimination of all forms of Discrimination against Women (‘CEDAW’) which safeguards the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, as well as to attain the highest standard of sexual and reproductive health.

This relatively restricted view on reproductive rights includes as its core elements: the right to found a family (Art. 16 CEDAW, Art. 32 International Covenant on Civil and Political Rights [1966] [‘ICCPR’]); the right to decide, freely and responsibly, the number and spacing of one's children (Art. 16 CEDAW, Art. 24 Convention of the Rights of the Child [‘CRC’], Art. 17 ICCPR, and Art. 12 International Covenant on Economic, Social and Cultural Rights [1966] ([‘ICESCR’]); the right to access to family planning information and education (Art. 16 CEDAW, Art. 13 CRC, Art. 19 ICCP, and Art. 13 ICESCR); and the right to access to family planning methods and services (Art. 16 CEDAW, Art. 24 CRC, and Art. 12 ICESCR). Supporters of this narrow position do not exclude the possibility of other rights to be related to reproductive freedom or choice, insofar as the violation of the particular right affects reproduction (see also Health, Right to, International Protection; Trade and Labour Standards). However, from this perspective, these general human rights are not constitutive per sex of reproductive rights (Packer 83).

Regarding the second and wider position, reproductive rights ‘embrace certain human rights that are already recognized in national laws, international human rights documents, and other relevant

UN consensus documents'. The right to life (Art. 3 Universal Declaration of Human Rights [1948] ['Universal Declaration'], Art. 6 (1) ICCPR, and Art. 6 (1) (2) CRC; Life, right to, International Protection), including the right not to die from preventable, pregnancy-related causes.

• The right to health (Art. 25 Universal Declaration, Arts 10 (2), 12 (1), and (2) ICESCR, Arts 12 (1) (2), 14 (2) CEDAW, and Art. 24 (1) (2) CRC), including the right to reproductive health.

• The right to personal freedom, security, and integrity (Arts 3 and 5 Universal Declaration, Arts 7, 9 (1) ICCPR, and 37 (a) CRC), including the right not to be subjected to torture or cruel, inhuman, or degrading treatment (Torture, Prohibition of).

• The right to be free of sexual and gender violence (Arts 5 and 6 CEDAW and Arts 19 (1) and 34 CRC; Gender Based Crimes).

• The right to decide the number of spacing of one's children (Art. 16 (1) CEDAW), including the right to reproductive self-determination and the right to make family planning choices.

• The right to privacy (Art. 17 (1) (2) ICCPR and Art. 16 (1) (2) CRC), including the right to decide freely and without arbitrary interference with one's reproductive functions (Privacy, Right to, International Protection).

• The right to equality and non-discrimination (Art. 2 Universal Declaration, Art. 2 (1) ICCPR, Art. 2 (2) ICESCR, Arts 1, 3, 11 (2) CEDAW, and Art. 2 (1) (2) (5) CRC), including the right to non-discrimination in the area of life and reproductive health.

• The right to consent to marriage and equality in marriage (Art. 16 (1) (2) Universal Declaration, Art. 23 (2) (3) (4

Sexual and reproduction health is a global occurrence from Asia, to Europe, America and Africa. According to USAID Bureau of Africa (2012) and its partner have identified Malawi, Ethiopia and Rwanda as the countries which have used the modern contraceptives methods to reduce teenage pregnancy.

The Rwanda can continue to learn from others countries like Malawi, and Ethiopia to reduce teenage pregnancy among teens Ethiopia It has been noted that the increased demand in family planning has become a cultural since the ICPD held in Cairo in 1994. The key successes in Ethiopia

family planning such as Personal commitment and leadership of the Minister of Health and Prime Minister, bringing services to the doorstep in the rural areas through the Health Extension Workers mentioned but few can help the Rwanda to overcome to unwanted teenage pregnancy among youths.

2.3 EMPIRICAL REVIEW

This case study is about fertility and Family Planning in Rwanda and how it addressed the SRH issue according to the census of 2012. The 2012 census indicates that females comprise about 52% of the total population (i.e. over 5 million persons). About 51.2% of the female population (i.e. 2.6 million) are women of reproductive age (i.e. between 15 and 49 years). In the same year, the average age of first marriage was estimated at 25 years for women and 27 years for men. Although Rwanda continues to experience increasing population growth in absolute numbers, population growth (%) slowed down from 3.2% in 2002 to 2.6% in 2011 (Ministry of Finance and Economic Planning, 2013) with total fertility dropping from 6.1 children per woman to 4.2 children per women at reproductive age between 2005 and 2014/15 (National Institute of Statistics of Rwanda et al. 2015). According to analysts, one of the key factor for the population growth is unplanned pregnancy, a phenomenon which was later aggravated by the situation of COVID19 between 2019-2022. Overall, in 2017, young people under the age of 20 years made up over 50% of the Rwandan population. Because of the large number of young women (large cohort) who will soon enter their reproductive years, even as the fertility rate declines, Rwanda's population will initially continue to grow significantly for the next few years. It is important to note that teenage fertility increased from 4.1 to 7.3 children between 2005 and 2015. This increased fertility rate among teenagers is worrisome as the 2012 census estimated that adolescents represented over 22% of the Rwandan population (Rwanda Ministry of Health, 2012). Therefore, Rwanda's youth population needs to be empowered to become the driving force behind economic prosperity and change agents in the coming years. Rwanda is among the most densely populated countries in Africa. As a result, the Government of Rwanda (GoR) has been committed to demographic transition measures as documented since the Vison 2020 and other relevant Government strategic documents, among them, teaching youth about sexual and reproductive health.

The focus has been on sustaining the campaign on responsible Family Planning (FP), increasing the uptake of contraceptive (especially the modern) methods for both men and women, encouraging small family size, and improving the living conditions of Rwandans through universal access to health and basic education (Ministry of Finance and Economic Planning, 2013). Overall, effective Family Planning has many benefits. These include reductions in poverty, economic inequality, gender inequality, and maternal and child mortality; empowerment of women by reducing the burden of excessive childbearing; improving women's productivity; and enhancing environmental sustainability through population stabilization (Cleland et al.2006; Prata et al. 2010). The businesses case for Family Planning (FP) in Rwanda is one of the most cost-effective ways of improving maternal and child health outcomes including reductions in infant, child and maternal mortality (Cleland et al. 2006; Cates, 2010; Kohler and Behrman, 2014).

Additionally, access to voluntary Family Planning helps men and women decide freely, and for themselves, whether, when, and how many children they want to have, thus lowering the number of unplanned pregnancies and births, but still with the situation of COVID19 today, a special focus needs to be put on teenagers. Smaller family sizes help to create a path out of poverty for many families. Indeed, the nation and families have more resources per child to invest in their education and health, thus enhancing the overall human capital. Slower population growth helps to build more resilient infrastructure for sectors like health and education and has the potential to accelerate economic growth (Canning et al. 2015; Starbird et al.2016).

In the post-2015 development agenda, investment in effective Family Planning has been demonstrated to have significant potential to contribute to the achievement of the Sustainable Development Goals (SDGs) resulting in substantial Government savings and a demographic dividend (DD) (Petruney et al.2014). In general, effective and sustainable Family Planning programs can be achieved through a combination of factors including (i) high-level political commitment, (ii) multisector collaboration (iii) adequate funding, (iv) having smaller families and using modern contraceptives, and (v) making a range of methods available through health facilities, social marketing, and outreach services and organizing SRH campaigns at the community level (Cleland et al.2006).

2.4. THEORETICAL FRAMEWORK

2.4.1. The Sexual and reproductive Theory of Change of Karl Marx

This theory is used to explain sexual and reproductive health and it links well with our study. The theory discusses both sexual and reproductive. This theory, together with the Human rights theory of change was developed by Oxfam in 2015. The tenets of this theory agree on the tremendous potential of the young generation to be present and future drivers of sustainable development and sustainable change. Given this, any threat to this category of people is a threat to the future and a threat to sustainable livelihoods and development. Considering the possibility and the power of collective action, Oxfam (2015) has developed a theory of change to explore what needs to happen so that young people, institutions, and communities can create equitable, transformative, and sustainable change together. If we link this study, the youth must be agents not, clients of whatever is planned for them. Even in the campaign for SRH, they must be key actors. The UNFPA took over the idea and put in place a strategic plan that successfully implements this theory (UNFPA, 2018-2021). UNFPA highlighted some principles that will guide UNFPA's work to make it successful. They include but are not limited to:

- Access to affordable, quality integrated SRH services that meet human rights standards;
- The need for strengthened accountability to eliminate all forms of discrimination; and
- The aim of empowering the most marginal groups, with a focus on women, adolescents and youth (particularly girls), and key populations at higher risk of HIV and other health challenges.

It has been observed that sexual and reproductive health can only be achieved when some requirements are met. Indeed, equitable access to quality, integrated services is essential in assuring that sexual and reproductive health and reproductive rights are protected. (UNFPA, 2018). The first outcome of the strategic plan thus focuses on an integrated approach to the realization of rights and the reduction in inequalities that mark the delivery of services in family planning, maternal health, and HIV, mainly through strengthening health systems. Young girls are always

vulnerable in peacetime or humanitarian contexts, in the context of our study, COVID 19 has aggravated the situation. With the lockdowns, people were squeezed together and young girls were tempted to do sex and get pregnant, with high a risk of getting sexually transmittable diseases. This is highlighted by UNFPA which noted that in humanitarian contexts, women and girls' vulnerability to GBV is particularly acute. Furthermore, Adolescents, particularly girls who live in poverty or with other disadvantages and forms of marginalization, encounter numerous barriers to exercising their rights to comprehensive sexuality education and sexual and reproductive health services. It is, therefore, a must to work together with partners to eliminate barriers in access to knowledge and services, with a particular focus on women and more so on teenagers. The fourth outcome focuses on the linkages between sexual and reproductive health and reproductive rights, population dynamics, poverty, and sustainable development. It thus integrates the UNFPA mandate into the broader development and humanitarian agenda.

2.4. 2. Sustainable Livelihood theory by Robert Chambers

Livelihood thinking theory dates back to the work of Robert Chambers in the mid-1980s. In realizing that conventional development concepts did not yield the desired effects and that humankind was additionally fag an enormous population pressure, Chambers developed the idea of "Sustainable Livelihood to stop enhance the efficiency of development cooperation. This theory is well linked to our study because teenage pregnancy is in big a part an issue of livelihood. Poverty pushes young girls to exchange sex for money and get exposed to sexually transmitted diseases, all of that linked to the search for livelihood. In this case, we can't say that this kind of livelihood is sustainable as it bears different threats and risks.

In this way, this theory has to be understood basically as a tool, or checklist, to understand poverty in responding to poor people's views and their understanding of poverty. Its application is flexibly adaptable to specific local settings and to objectives defined in a participatory manner. According to Chambers and Conway (1992:9) "a livelihood comprises the capabilities, assets and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base."

One of this these principles is “people-centered”, meaning that people rather than the resources they use are the priority concern in the livelihoods approach, since problems associated with to development often root in adverse institutional structures impossible to be overcome through simple asset creation. Therefore, sustainable poverty reduction will entail success only if development agents work with people in congruency with their current livelihood strategies, social environment and capabilities to adapt. At a practical, level this implies a detailed analysis of people's livelihoods and their dynamics over time. Coming back to our study, the SRH campaign mustn’t be an action of the Kicukiro district, but they must first involve people, especially the victims who were exposed more to poor SRH knowledge.

2.5 CONCEPTUAL FRAMEWORK

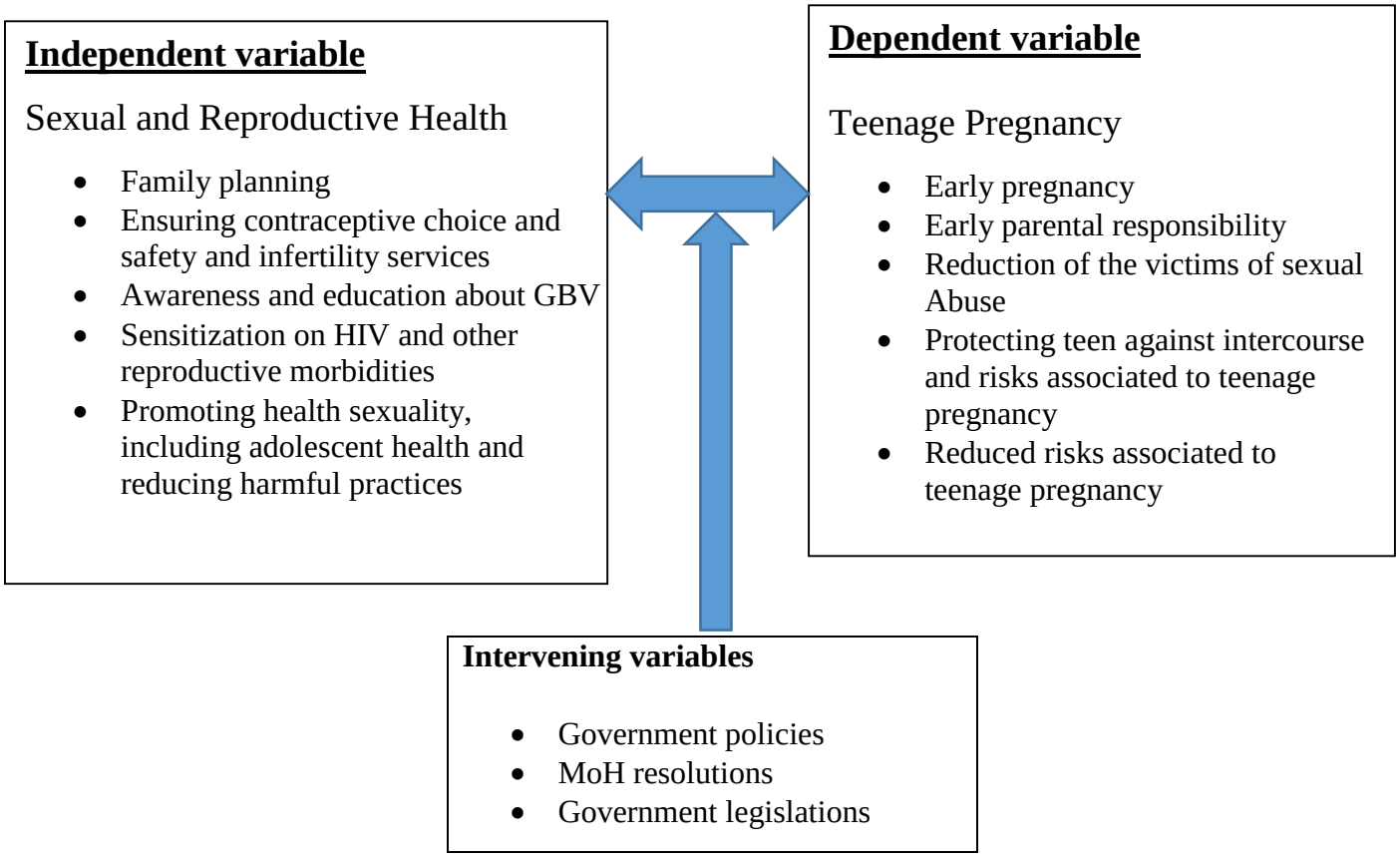

Figure 2: Conceptual framework

Source: Adopted from the literature review

2.5 CONCLUSION

This chapter discussed different literature talking about sexual reproduction health. In summary, we have found that an effective and sustainable Family programmes can be achieved through a combination of factors including such as high-level political commitment, mutlti-sectoral collaboration, adequate funding, having smaller families and using modern contraceptives through, making a range of methods available through health facilities, social marketing, and outreach services and organizing SRH campaigns at the community level

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 INTRODUCTION

This study discussed the method to be used to reach the objectives of the study and to answer the research objectives. Methods and techniques were used throughout the study from data collection, data integration, analysis, and interpretation. Furthermore, the limitations of this study and ethical considerations are discussed in this chapter.

3.1 Sampled Population

The Population refers to the set or group of all the units on which the findings of the research are to be applied (satishprash shukla,2020).

3.1. Description of the study

Kicukiro District is one of the 3 Districts which constitute the city of Kigali and is situated in South East of the City of Kigali. It is made up of ten administrative sectors such as Kicukiro, Kagarama, Niboye, Gatenga, Gikondo, Gahanga, Kanombe, Masaka and Nyarugunga. It has 41 cells and 333 administrative villages. The District covers a total area of 166.7 km2, and the populations are 319, 66.

3.2. RESEARCH DESIGN

This study is computer desk-based. Indeed, I read the abundant literature on the question, and from there, I will identify the gap that will be filled by the new knowledge I am striving to discover. Interviews with teenage victims and any other person who deals with teenage pregnancy will be conducted. They include but are not limited to local leaders, health workers, the ministry of youth, Ministry of health, the ministry of gender, and the National Commission for children, to name but a few. Questionnaires will be distributed to victims and other selected people to enable the researcher to understand the issue under study better. Candidates for interviews will be chosen randomly. All the items under consideration in any field of inquiry constitute a universe or population. It can be presumed that in such an inquiry, when all the items are covered, no element

of chance is left, and the highest accuracy is obtained (Kothari, 2004). This included respondents from Gikondo and Gahanga sectors in city of Kigali. The total target population is 300 people. The total population was made of victims, local leaders, experts from concerned ministries, and parents, as detailed in the table below:

Category of population	**Total population**	**Simple size**
Victims	200	50
Leaders	10	5
Experts from concerned ministries	10	5
Parents	70	15
Total	300	75

Source: Field data, 2021

Sample size determination

The sampling formula proposed by Yamane in 1967 was used for calculating the sample size on the side of passenger or population

$n=N/1+N\ (e)^{2}$

Where n= sample size

N= total population,

e= sampling error (0.1)

For this research, the researcher took a sample with 90% of confidence and 10% error of estimation, and the sample size is:

n=300/1+300(0.1*0.1)

n= 300/1+300(0.01)

n=300/4

n= 75

Researcher after calculating the sample size by using Yamane formula, respondents was selected. The following will be taken into account while determining the sample size if we want to avoid errors:

- Confidence Margin (Margin of error)
- Confidence level

The confidence margin measures the degree of uncertainty or certainty in a sampling method and how much uncertainty there is with any statistic. In simple terms, the confidence interval tells you how confident you can be that the results from a study reflect what you would expect to find if it were possible to survey the entire population being studied. The Confident level refers to the percentage of probability or certainty that the confidence interval would contain the valid population parameter when you draw a random sample many times. It is expressed as a percentage and represents how often the ratio of the population who would pick an answer lies within the confidence interval.

3.3. RESEARCH METHODS

In responding to the objectives of this study, both qualitative and quantitative methods were used. Qualitative research is recommended when samples are small, and their outcomes are not measurable and quantifiable. It offers a complete description and analysis of research subjects without limiting the research and the nature of participants' responses (Collis and Hussey, 2003). Quantitative research is to classify features, count them and construct statistical models to explain what is observed. Questionnaires or equipment to collect data are used.

3.4. DATA COLLECTION AND TECHNIQUES

For this study, personal and unstructured interviews were used to collect the data. According to Fisher, 2005 the main advantage of personal interviews is that they involve personal and direct contact between interviewers and interviewees and eliminate nonresponse rates. Still, interviewers need to have developed skills to carry out an interview successfully. However, unstructured interviews offer flexibility in terms of the interview flow, thereby leaving room for the generation of conclusions that were not initially meant to be derived. (Gill and Johnson, 2002).

3.5. DATA PROCESSING METHODS

Data processing is when a research frame collects data through editing, coding, classifying, charting, tabulation, and diagramming. The purpose of data processing in research is data reduction or minimization. This processing transforms irrelevant into relevant data. According to Battaggia.C. et al. (2015). Data processing is a series of actions or steps performed on data to

verify, organize, transform, integrate, and extract data in an appropriate output form for subsequent use. Data processing in research consists of five important steps, which are:

Editing of data: The process of examining data collected in questionnaires to detect errors and omissions and ensure that they are collected, and schedules are ready for tabulation.

In this study, editing for quality and editing for tabulation were used.

Coding of data: is necessary for efficient analysis, and through it, the several replies may be reduced to a small number of classes that contain the critical information required for analysis. In other words, coding is the process by which data/responses are organized into classes, categories, and numerals or other symbols given to each item according to the class it falls.

In this study, categories to be used and individual answers were allocated to them during the whole process.

Classification of data/categorization is the process of grouping the statistical data under various understandable homogenous groups for convenient interpretation.

This study collected quantitative and qualitative data from various sources and classified them accordingly.

Tabulation: is the process of summarizing raw data and displaying it in compact form for further analysis. Tables were used in this study.

3.6. METHODS OF DATA ANALYSIS

Data analysis systematically applies qualitative data analysis techniques to describe and illustrate, condense and recap and evaluate data. Data analysis is the process of collecting and analyzing data to extract insight that supports decision-making. There are various methods and techniques to perform data analysis depending on core areas: quantitative and qualitative methods in research. (Attride-Stirling 2001).

In this study, individual and structured interviews were designed to elicit the interviewee's knowledge of the study topic. We have, first of all, identified people with firsthand knowledge of the topic. They include but are not limited to local leaders who supervise the SRH campaign in the Kicukiro district and health experts. Questionnaires were carefully considered to serve us in collecting results. The people interviewed were selected randomly. (Pope. C et al. 2000).

3.7. ETHICAL CONSIDERATION

This study will respect ethical requirements. The data collected from various people will be kept confidential and will only be used in this research to meet its expected objectives. No alterations will be made to the answers provided by the respondents. Corruption will be at all costs prohibited. In conducting this study, interviewees and other respondents were briefed, and in turn, they willingly participated in this study. We agreed to keep their identities secret and assured them that answers will only be used for research purposes Ethical considerations.

3.8. RESEARCH LIMITATIONS

Talking to victims will not be easy. We will therefore request local leaders to help us to find them. The size of the sample was small. A bigger sample would have helped us to increase the reliability of the research and therefore to minimize the margin of error. Time and money will be difficult to get because of the busy schedule of the University.

3.9 CONCLUSION

This chapter was about research methodology which highlighted the research methods which were used by the searcher to collect data to conduct this study. This study was qualitative and some tables were used and figures interpreted. In this study, ethical issues were respected by all means

CHAPTER FOUR
DATA PRESENTATION, ANALYSIS, AND INTERPRETATION

4.1. Introduction

This chapter presents the study findings. The researcher presents the research findings from the respondents involved in the study. The main objective of this study was to investigate the extent to which a campaign in reproductive health can address a teenage pregnancy situation.
As such study responded to the following questions:

4.2. Bio-Data of Respondents.

4.2.1. Gender of Respondents

Due to the nature of the study, the researcher had a vested interest in the gender of respondents. The findings are as shown below.

Table 1: Characteristics of respondents by gender

Gender	Frequency	Percentage
Male	33	44
Female	42	56
Total	75	100

Source: Field data, 2021

By gender, both males and females were represented as interpreted below. Males were 44% of the entire respondents, while females accounted were 56%. This means that more females are more involved in SRH campaigns than males. This portrayed that both males and females presented all gender, and therefore there was no bias in the research project.

4.2.2. Respondents age

Interpretation according to age. Responses are presented in the table below.

Table 2: Respondents' age

Age group	Frequency	Percentage
18-25	21	28%
26-35	18	24%
36-45	21	28%
46-55	15	0%
Total	75	**100**

Source: Field Data, 2021

According to age, 28% represented age bracket group of (the 18-25), 24% represented the age bracket group (26-35), 28% represented the age bracket group bracket of (36-45), and 20% represented the age bracket group of (46-55). Therefore, the young, the old, and the mature were all represented.

Table 3: Field Data 2021

Marital status	Frequency	Percentage
Married	30	40%
Single	45	60%
Total	75	**100%**

Source: Field Data 2021

Table 3 shows that married and single people interviewed were 40% and 60%, respectively. This shows how the family is affected by the issue under study.

Table 4: Respondents' Educational level

Education level	Frequency	Percentage
Certificate	12	16%
A2	29	38.66%
A1	11	14.66%
Bachelor's Degree	15	20%
Master's Degree	8	10.66%
Total	75	**100%**

Source: Filed Data, 2021

The certificate results had 54.66%, diploma level had 14.66%, bachelor's degree had 20%, and master's degree had 10.66

4.3 KEY ISSUES IDENTIFIED DURING THE FIELDWORK

4.1. The Causes of the high rate of teenage pregnancy in Kicukiro are diversified

This session is linked to objective one of this research **"**to investigate to root cause of the high rate of teenage pregnancy in Kicukiro district". According to table 5 below, the dissemination of information isn't enough to raise awareness and this is one of the root causes of the increase in teenage pregnancy.

Table 5: SRH campaigns status in Kicukiro District

Access to SRH information	Frequency	Percentage
Dissemination of information in Primary and Secondary schools	31	41.33%
Information for teens not attending schools	11	14.66%
Information to parents	13	17.33%
Use of media in the dissemination of information on SRH	12	16.00%
Dissemination of information through churches	8	10.66%
Total	75	**100%**

Source: Field Data 2021

All the respondents agreed that the dissemination of SRH services in Primary and Secondary Schools reached 41.33%; access to information to teens not attending or dropped from schools 14.66%; information to parents 17.33%; information through media 16.00%, information through churches 10.66%. This implicitly indicates that access to information for teens is very low. Therefore, SRH campaigns and the spread of information should be intensified. The researcher observes that Starrs et al. (2018) said that all individuals have a right to make decisions on their bodies and access services that support that right, at the same time, every teen needs to have enough information about their reproductive health to manage to make good decisions. The argument of individual rights mentioned by WHO (2014) highlights that every individual has the right to make their own choices about their sexual and reproductive health, which implies that people should be able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so (WHO, 2004), but as mentioned earlier, this choice needs to be oriented by the information they have on reproductive health. Another root cause is the way that teenage access to SRH services in Kicukiro District is mentioned in table 6.

Table 6: Access to SRH services in Kicukiro District

Access to SRH services to teens (15-19 years)	**Frequency**	**Percentage**
Family Planning	26	34.66%
Use of contraceptives	10	13.33%
Maternal and new-born healthcare	9	12%
Prevention, diagnosis, and treatment of STDs	18	24.00%
Elimination of GBV	12	16.00%
Total	75	**100%**

Source: Field data, 2021

The respondents provided us with their knowledge of the SRH services offered to teenagers in the Kicukiro District as follows: family planning (34.66%), use of contraceptives (13.33%), Maternal and newborn healthcare (12%), Prevention, diagnosis, and treatment of STD's (24.00%) and the elimination of GBV (16.00%). What can be observed, is the way teenagers get services on SRH services in Kicukiro District is a problem, it is too low, whether it is family planning, access to

contraceptives, maternal and new-borns healthcare, prevention, diagnosis, and treatment of STDs, and the elimination of GBV, the access is very low and this is another contributing factor to the increase of teenage pregnancy. As mentioned by UNFPA (2018), it has been observed that sexual and reproductive health can only be achieved when some requirements are met; including the level of access to services linked to SRH. Indeed, equitable access to quality, integrated service is essential in assuring that sexual and reproductive health and reproductive rights are protected. (UNFPA, 2018)

Table 7 is linked to objective three of this research "to explore the way SRH campaign responds to the teenage pregnancy issue in Kicukiro District". These challenges vary from lack of enough information for teenagers, religion and cultural beliefs, lack of information to parents/Guardians, SRH campaigns limited to some groups, lack of SRH services in Health centers and Hospitals, to ignorance and poverty.

Table 7: The Challenges to the SRH access and Services

C**hallenges to SRH access to information and services**	**Frequency**	**Percentage**
Not enough information for teenagers	9	12%
Religion and cultural beliefs	14	18.66%
Lack of information to parents/Guardians	9	12%
SRH campaigns are limited to some groups	10	13.33%
Lack of SRH services in some Health Centers and Hospitals	11	18.66%
Ignorance and poverty	13	17.33%
Low level of Sensitization among stakeholders	9	12%
Total	75	**100%**

Source: Fieldwork data, 2021

Based on the findings on the challenges to SRH access and services, contributing variables are as follows: Not enough information for teenagers (12%), Religious and cultural beliefs (18.66%), Lack of information to parents/guardians (12%), SRH services limited to some target groups

(13.33%), Lack of SRH services in some Health Centres and Hospitals (18.66%), ignorance and poverty (17.33%), Low level of sensitization among stakeholders (12%). More challenges were mentioned by Seetesh Ghose and Lopamudra B John, (2017) who show that the reproductive event makes teenagers more vulnerable to complications resulting in devastating health consequences. They include but are not limited to dropping out of school and health problems that jeopardize their income-earning potential (Seetesh Ghose and Lopamudra B John, 2017).

Table 8 is linked to objective 2 of this research "to explore the way SRH campaign responds to the teenage pregnancy issue in Kicukiro District". This varies from disseminating SRH information to the Youth not attending schools, putting in place parents' fora were to discuss SRH information and access, using media in SRH campaigns, involving men in SRH Campaigns, and challenging the religions' stance on SRH access and services, to establishing Poverty reduction schemes to poor families.

Table 8: Solutions to the identified challenges

Revisiting SRH campaigns by:	**Frequency**	**Percentage**
Disseminating SRH information to the Youth not attending schools	14	18.66%
Putting in place parents' fora where to discuss SRH information and access	12	16.00%
Using media in SRH campaigns	16	21.33%
Involving men in SRH Campaigns	12	16.00%
Challenging the religions' stance on SRH access and services.	11	14.66%
Establishing Poverty reduction schemes for families	12	16.00%
Total	75	**100%**

Source: Field data, 2021.

Most of the respondents agreed that access to SRH information and services should be revisited and propose to put more emphasis as proposed here below: disseminating SRH information to the youth not attending schools(18.66%), putting in place parents a to discuss SRH (16.00%), Using media in SRH campaigns(21.33%), involving men in SRH campaigns(16.00%), Revisiting religions' stance on SRH access to information and services (14.66%) and establishing Poverty reduction scheme to poor families(16.00%).

The International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, and its resulting Programme of Action recognized that reproductive health, including sexual health and reproductive rights, as well as gender equality and women's empowerment, are critical to improving the quality of life for everyone. (WHO, 2016). This issue requires addressing all means, including educating all people involved. Indeed, access to comprehensive sexuality education is essential. According to the UN Millennium Project Report, the World Health Organization (WHO: 2004) outlined five components that are necessary for good sexual and reproductive health: ensuring contraceptive choice and safety and infertility services, improving maternal and newborn health, reducing sexually transmitted infections, including HIV, and other reproductive morbidities, eliminating unsafe abortion and providing post-abortion care and promoting healthy sexuality, including adolescent health, and reducing harmful practices.

4.4 CONCLUSION

This chapter was based on data presentation, analysis, and interpretation. It covered respondents' gender, the respondents' age, respondent's marital status, Respondents' level of education level, SRH campaigns status in Kicukiro District, Access to SRH services in Kicukiro District, challenges to SRH access to information and services, and, solutions to the identified challenges.

CHAPTER FIVE

GENERAL CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study showed that SRH is a global phenomenon but focused on Kicukiro as a case study. We have seen that an awareness campaign was organized in Kicukiro district with positive results at the field. The campaign mostly targeted the youth. The awareness varied from disseminating SRH information to the Youth not attending schools, putting in place parents' fora were to discuss SRH information and access, using media in SRH campaigns, involving men in SRH Campaigns, and challenging the religions' stance on SRH access and services, to establishing Poverty reduction schemes to poor families.

5.1 General conclusion

In conclusion, all the three research questions were answered by the primary data from respondents in the Kicukiro district backed up by the theories that the research has chosen as seen in chapter two, the literature reset, the first research question was about **"**what are the causes of the high rate of teenage pregnancy in Kicukiro district?" All the respondents agreed that the dissemination of SRH services in Primary and Secondary Schools reached 41.33%; access to information to teens not attending or dropped from schools 14.66%; information to parents 17.33%; information through media 16.00%, information through churches 10.66% (see table 5, p.28).

The second research question was "what are the ways the SRH campaign responds to the teenage pregnancy issue in Kicukiro District?" Most of the respondents agreed that access to SRH information and services should be revisited and propose to put more emphasis as proposed here below: disseminating SRH information to the youth not attending schools(18.66%), putting in place parents to discuss SRH (16.00%), Using media in SRH campaigns(21.33%), involving men in SRH campaigns(16.00%), Revisiting religions' stance on SRH access to information and services (14.66%) and establishing Poverty reduction scheme to poor families(16.00%)(see table 8, p.31). The third research question was **"**what are the challenges met during the SRH campaign in Kicukiro and what can be proposed as a way forward?" Based upon the findings on the

challenges to SRH access and services, contributing variables have been observed. We have found that the lack of SRH services in some Health Centres and Hospitals rated by respondents at 18.66% is the highest together with religious and cultural beliefs rated by the respondents at 18.66%, and followed by ignorance and poverty rated at 17.33% by the respondents (see table 7, p.30).

5.2 Recommendations

5.2.1 To Kicukiro district

The effort of a campaign of Sexual Reproduction Health has shown to be effective, this means that you have learned experience to share with other districts and communities. Hence, this needs to be documented and written. Second, this must not be after a challenging situation like the outbreak of COVID19, but this must be a culture.

5.2.2 To Health sector in Rwanda

Using community health workers, this campaign must be deducted at the community level and coordinated by the health sector at a higher level as it is for other health cases. Indeed, community health workers have proved to be very effective at the community level and every community in Rwanda can observe that. That trust from the community can be a good asset in mobilizing the community for sexual reproductive health.

5.2.3 For teenagers

It is a fact that poverty is a high risk to get involved in sex in exchange for money, but this isn't an apology to give birth to children whom one didn't plan as this situation makes poverty even worse. There is a possibility to change to a better livelihood strategy, especially because the government of Rwanda is very supportive of youth. There is a possibility to learn skills that can help to earn a dignified living

5.2.4 For Ministry of Health

The Ministry of Health as a lead agency must coordinate the SRH efforts to reduce the rate of teenage pregnancy in Rwanda in general and Kicukiro in particular. The required synergy between the key partners will help to effectively the meager resources at our disposal and to avoid

overlapping efforts by partners. It is in this effort that a common strategic plan must be agreed on and implementation efforts be coordinated.

5.3 Areas for the further research

This study was focusing on the effectiveness of sexual reproductive Health Campaigns in Combating Teenage Pregnancy in KICUKIRO District. There are other related areas where studies an of big importance like:

- The problem linked to teenage pregnancy and how to solve them
- SRH and the role played by parent

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APPENDICES

APPENDIX

Questionnaire

The effectiveness of SRH campaigns on Teenage pregnancy in the Kicukiro District

This questionnaire is meant for different categories of people as follows:

A. Local leaders. (Leaders from ministries in charge of family promotion etc.)

1. How SRH campaigns are organized in your area?
2. What kind of people get involved in SRH campaigns?
3. Do you have a pre-established Programme in place for SRH campaigns?
4. What categories of people are targeted by those programs?
5. What is the impact of SRH campaigns on teenage pregnancy in your area?
6. What area of improvement do you recommend putting more emphasis on?
7. What can we do differently to get good results in the future?
8. How do you target teenagers who are attending schools? Do they ha ave specific Programme?
9. How frequent are SRH campaigns conducted in your area?
10. Are you satisfied with the work done?
11. What are your plans for conducting SRH campaigns for teenagers?
12. What are the stakeholders in these campaigns?
13. What is the role of men in this endeavor? If they are not involved, why?

B. Victims (including teenagers)

14. Have you heard about SRH services?
15. Have you benefited from SRH services?
16. Have ever attended any SRH campaigns? What did you learn from there?
17. How many times did you attend the SRH campaigns?
18. Is the knowledge acquired from SRH campaigns enough to stop teenage pregnancies?
19. Is there any specific category of people to be invited to the SRH campaigns?
20. Should we invite men to SRH campaigns? If yes or no, Why?

21. What is the role of parents in SRH campaigns? Should we invite them?
22. What are the consequences of not attending SRH?
23. How have you dealt with those consequences?

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AUTHORISATION TO SUBMIT THE CORRECTED DISSERTATION

I, undersigned, **Dr Alex LUBERWA**, member of the panel of examiners of the dissertation presented by **Angelique UWAMARIYA** entitled: "**THE EFFECTIVENESS OF SEXUAL REPRODUCTIVE HEALTH CAMPAIGNS IN COMBATING TEENAGE PREGNANCY IN RWANDA: CASE STUDY OF KICUKIRO DISTRICT"**

Hereby testify that, she successfully entered the suggested corrections by the panel of examiners and stands with authorization to submit required copies to the administration of CCM for administrative purpose.

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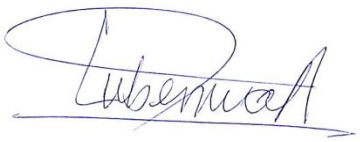

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TO WHOM IT MAY CONCERN

This is to certify that **SP ANGELIQUE UWAMARIYA** is a student at Rwanda National Police College, undertaking a Master's Degree in Peace Studies and Conflict Transformation for the academic year 2021-2022. She is conducting a research on: "THE EFFECTIVENESS OF SEXUAL REPRODUCTIVE HEALTH CAMPAIGN IN COMBATING TEENAGE PREGNANCY IN RWANDA: CASE STUDY OF KICUKIRO DISTRICT", for which she is required to collect data from relevant sources.

Any assistance rendered to her in this regard is highly valued by the College.

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