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Socio-Cultural Barriers Influencing Unplanned Pregnancy in Mugombwa Refugee Camp, Rwanda: Female Adolescents' Perspectives

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Abstract: Female adolescents experience exacerbated vulnerability to the effects of gender inequities in refugee settings, where there is often a lack of protective societal structures and the politicization of their access to sexual and reproductive health (SRH) services, which result in an increase in teenage pregnancy as compared to non-refugee settings. In the Mugombwa refugee camp in Rwanda, there were 47 adolescent childbirths in 2021 alone. This study explores the perspectives of female adolescents on the barriers underpinning adolescent unplanned pregnancy in the Mugombwa refugee camp. Focus group discussions were conducted with 16 adolescent girls between the ages of 10 and 19. The findings were analyzed using inductive and deductive thematic analysis. Barriers at the individual, interpersonal, communal, and institutional levels underpin unplanned adolescent pregnancy. Socio-cultural barriers of poverty and transactional sex, poor knowledge of contraceptives, negative peer influence, sexual coercion, poor parent–adolescent communication, negative health worker attitudes, selective SRH community outreach, and the inaccessibility of contraceptives emerged as themes influencing the sexual behavior of adolescents and unplanned pregnancies. The socio-cultural barriers and systemic facilitators of gender inequality associated with being an adolescent female in a refugee camp must be prioritized to alleviate adolescent unplanned pregnancy.

Keywords: adolescent health; sexual and reproductive health; unplanned pregnancy; refugee camp; sociocultural factors; Rwanda; gender equity



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1. Introduction

The sexual and reproductive health of adolescents, particularly in developing countries, is one of the key public health and development concerns of governments, non-governmental organizations, policymakers, and state actors worldwide. Sexual and reproductive health (SRH) is vital to ensure the highest well-being of adolescents across genders. The World Health Organization (WHO) states that reproductive health “is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes . . . ” [1]. Adolescents, as defined between the ages of 10 and 19, represent a particularly vulnerable population due to their entry into puberty and sexual experiences [2,3]. Puberty and early sexual experiences inform adolescents' sexual and reproductive health for a lifetime [4]. Early sexual experiences are predictive of future sexual behaviors, including contraceptive use, sexual agency and decision-making, sexual health-seeking behavior, and outcomes relating to unintended pregnancies, sexually transmitted infections (STIs) including human immunodeficiency virus (HIV), and sexual subjugation [4]. Adolescents in low-middle-income countries (LMIC) possess the largest global burden of poor SRH

outcomes, including unplanned pregnancies, unsafe abortion, and HIV/STIs [5]. Globally, adolescents face disproportionate sexual and reproductive health burdens. In several countries, 10–15% of the total annual fertility is from adolescent pregnancies between the ages of 15 and 19 [4]. In 2016, an estimated 777,000 births occurred among young adolescent females, out of which 58% of births took place in Africa [5]. In sub-Saharan Africa (SSA) specifically, most unintended pregnancies are adolescent pregnancies, where one in five adolescents become pregnant during their adolescent years [4,6]. The susceptibility of female adolescents to poor SRH outcomes is underpinned by gender-based violence, gender norms, and unequal power relations [7,8].

Refugee settings exacerbate adolescent SRH risks and challenges due to a lack of protective societal structures and transient resources [8,9]. The United Nations High Commissioner for Refugees (UNHCR) conducted an inter-agency global evaluation of reproductive health services for refugees and internally displaced persons in 2004 and found that most people affected by conflict lack adequate SRH care and adolescents specifically are often underserved [9,10]. Refugee camps experience constrained access to education, employment, participation, and protection, which puts adolescent refugees at the mercy of what is provided in the camp itself [10,11]. Adolescents experience compounded vulnerability in refugee settings, where there is often a lack of emphasis on their SRH rights and the politicization of SRH issues and access to services [8,10,11]. Refugee settings experience increased instances of rape, trafficking, sexual exploitation, child marriage, and maternal death [8,10,12,13]. Moreover, 50% of refugees worldwide are adolescents, demonstrating the breadth of the need to address adolescent SRH needs and challenges in refugee settings [8].

Adolescent females experience distinct marginalization owing to their gender and age, which exacerbates their SRH issues. Adolescent refugee girls are at an increased risk of gender-based violence, sexual abuse, and unplanned pregnancy in refugee settings [10,11]. A study in a refugee setting in Uganda found that 25% of adolescents between 13 and 18 had ever had sex [14]. While a proportion of adolescent sexual activity is consensual, systematic reviews of sexual violence in refugee settings have found that one in five refugees experience sexual violence [15]. The literature also shows that there is a higher incidence of teenage pregnancy in refugee settings compared to non-refugee settings [12,16–18]. Furthermore, pregnant mothers in refugee settings are at an increased risk of complications and maternal mortality, unsafe abortion, prolonged labor and delivery, and preterm birth [19,20]. Compounding the health risks associated with adolescent pregnancy is the context of living in a refugee setting. Studies show that pregnancies in refugee settings experience greater adverse outcomes [21]. A maternal death review report of refugee camps in 10 countries found that unsafe abortion accounts for 78% of all maternal mortality among refugee women [22]. Furthermore, adolescent motherhood perpetuates a cycle of poverty by increasing the likelihood of dropping out of school, reducing career progression and economic empowerment [23,24]. From an intersectional feminist lens, it becomes clear that social categories, in combination with structures of power, create a unique experience of SRH for adolescents.

Preventing adolescent pregnancies requires a contextual understanding of the factors contributing to them to design interventions and policies that capture adolescents' SRH needs and challenges [25,26]. Despite the availability of research on the determinants of adolescent pregnancy, research on adolescent pregnancy in refugee settings remains minimal. Refugee settings act as unique ecosystems, harboring sub-cultures, practices, and customs that require a context-specific analysis to understand the determinants of adolescent pregnancy. Rwanda has been the home to 127,000 refugees from neighboring countries across six refugee camps since 1997 [27]. A study in the Gihembe and Nyabiheke refugee camps assessed the social and economic vulnerabilities of female adolescents and found that lack of economic opportunity, female gender norms, material deprivation, and vulnerability led to transactional sex and exploitation within and around the camps [10]. Another study conducted by the UNHCR in the Gihembe and Kiziba refugee camps in

Rwanda identified that early pregnancy and prostitution were the top harms that girls face [12]. Similarly, a study in the Kigeme refugee camp in Rwanda found that sexual abuse such as rape, unwanted physical touching, sexual exploitation, commercial sex, early marriage, and girl trafficking, were facilitated by the camp conditions, lack of security, and adolescent developmental stage [13].

The Mugombwa refugee camp, established in 2016, currently hosts approximately 11,304 refugees primarily from the Democratic Republic of the Congo, of whom 18.4% are between the ages of 12 and 17 [28]. In 2021 alone, there were 47 births from individuals below 20 years of age in the Mugombwa refugee camp [29]. From January to June of 2022, there were 25 births from individuals below 20 years of age [29]. Research conducted in six camps in Rwanda in 2015, including the Mugombwa refugee camp, showed that overall reproductive health service utilization was low among adolescents [23]. A similar study in 2016 found that gender gaps existed in all sectors across camps, including conditional pregnancy to increase family size and sex in exchange for basic needs [24]. However, limited published research exists concerning the SRH of adolescent female refugees in the Mugombwa refugee camp, and more specifically on the socio-cultural barriers across socio-ecological layers that influence teenage pregnancy. This study aimed to explore the sociocultural barriers underpinning adolescent unplanned pregnancy to inform the implementation of holistic approaches that alleviate the disparities in the sexual and reproductive health outcomes of female adolescents, especially regarding teenage pregnancy.

1.1. Positionality Statements

1.1.1. Autumn Eastman

I am a 26-year-old white female from a small rural town in Vermont in the United States. Having grown up in the United States, I do not have an intimate relationship with the Rwandan context, nor do I share the same experiences as refugee adolescents. My nationality and race often place me in a position of power and influence how people interact with me. For this reason, I occupy the position of an outsider in most facets of this research. Professionally, I have developed an intersectional feminist lens. I work with an ideology of emancipation from patriarchal structures and norms within which people socialized as women are subordinated.

1.1.2. Oluwatomi Olunuga

I am a 24-year-old black female from Lagos, Nigeria—an urban area. As an African, I am able to understand the Rwandan context in general, but I am unable to relate to the refugee experience. I mentor adolescents, which may help me understand adolescent behavior. My income and culture also differ from that of the target population, creating a gap in my understanding of their experience. As a result, I am an outsider in many ways in this study. However, because of my training in feminist research and intersectionality, I would be able to analyze and present the findings of this study from a feminist perspective.

2. Materials and Methods

2.1. Study Setting

This research study took place in the Mugombwa Refugee camp in Gisagara District, Southern province of Rwanda. Mugombwa was established in 2016 and is the home of 11,304 refugees, the majority of whom are from the Democratic Republic of the Congo (DRC) [28]. The camp is divided into eight quarters neighboring a local host community. Congolese refugees fled the DRC in the mid-1990s due to conflict between government forces and armed groups. The instability of state institutions, chronic violence, and remaining conflict over land ownership and citizenship prevent Congolese refugees from returning home [30]. Refugees in the Mugombwa camp, therefore, depend on support for their basic needs. UNHCR, in collaboration with African Humanitarian Action (AHA), works to provide refugees with essential services, including but not limited to sexual and reproductive health services [28]. AHA currently provides refugees with contraception,

antenatal and postnatal care, and access to safe labor at their health center. Additionally, AHA conducts monthly community-based SRH awareness sessions for refugees and health professionals.

2.2. Study Design and Sampling

A qualitative descriptive study design was employed utilizing focus group discussions. Purposive sampling was used to select 16 adolescent girls between the ages of 10 and 19 from primary and secondary schools living in the Mugombwa refugee camp, using the attendance sheets provided by school authorities. Consent and assent were obtained from the adolescents and their parents/guardians.

2.3. Data Collection

Two separate focus group discussion sessions were conducted with eight 10–14-year-olds and eight 15–19-year-olds using a semi-structured interview guide developed to understand the socio-cultural barriers influencing unplanned pregnancy among female adolescents in the Mugombwa camp. The adolescents were separated into two groups to investigate potential differences in perspectives between early adolescents and late adolescents. Additionally, as research often overlooks the voices of those aged 10–14 years, we deliberately included them while taking measures to prevent any influence from the 15–19-year-old adolescents on their responses. The interview guide consisted of open-ended questions to allow adolescents to freely explain themselves, followed by probes. The interview guide included the following topics: prevalent health concerns in the refugee camp, teenage pregnancy, the use of and accessibility of SRH services, factors influencing sexual behavior, satisfaction with SRH services available, and desires as it relates to the availability, appropriateness, and quality of SRH services. The interview guide was developed in English and translated by a native Kinyarwanda speaker from the University of Global Health Equity. The interview guide was also pretested by having one native Kinyarwanda speaker back-translate the questionnaire for accuracy. Two female data collectors, concordant with our study population, were trained over 4 h to use the interview guide and conduct the focus group discussions.

Data collectors acquired informed consent and assent before the interviews. In the event that a research participant and or their parents were illiterate, the data collector verbally explained the research study and consent form to the participant in Kinyarwanda and acquired signed consent. Participants who consented to participate were invited to a private, spacious, and easily accessible location provided by the schools for the focus group discussion. Each focus group discussion lasted approximately 90 min. The focus group discussions were conducted and recorded in Kinyarwanda. The recordings were also transcribed in Kinyarwanda and then translated into English for data analysis. Upon preliminary data analysis, the principal investigators deemed that data saturation had been reached.

2.4. Data Analysis

The data were coded manually using inductive and deductive coding. To ensure an intersectionality-informed analysis, a two-step hybrid approach developed by Sirma Bilge was used to analyze this data [31]. In the first step, two principal investigators independently manually reviewed each transcript and conducted open and axial coding of the qualitative data in order to identify emergent themes, patterns, and connections. In the second step, the principal investigators deductively reinterpreted the data using an intersectionality-focused analysis and the socio-ecological model to identify factors influencing unplanned pregnancy [31]. The investigators collaboratively compared the codes, which led to the collaborative deductive creation of themes under broad socio-ecological levels (individual, interpersonal, communal, institutional) based on their relation to unplanned pregnancies.

3. Results

The demographic characteristics of participants and the themes that emerged from the FGDs are presented below.

3.1. Characteristics of Participants

A total of 16 girls from the age groups of 10–14 and 15–19 participated in two separate FGDs. Two separate FGDs were conducted to create a welcoming environment for both early and late adolescents to express their thoughts freely without the potential inhibition of the other age group since early and late adolescents have the potential to influence each other's responses. All of the adolescents spoke Kinyarwanda and their parents were originally from the DRC. All participants lived in the Mugombwa refugee camp but attended one of two schools located outside the refugee camp which are integrated with adolescents from the host community.

3.2. Unplanned Pregnancy as a Leading Health Concern for Adolescents

When asked about what the primary health concerns are of an adolescent living in the Mugombwa refugee camp, participants frequently responded with unplanned pregnancy:

"Something that I realized, many adolescents from our camp get pregnant at an early age."

(10–14 years old girl)

The FGDs revealed sociocultural factors at the individual, interpersonal, communal, and institutional levels that influence adolescent unplanned pregnancy (Figure 1).

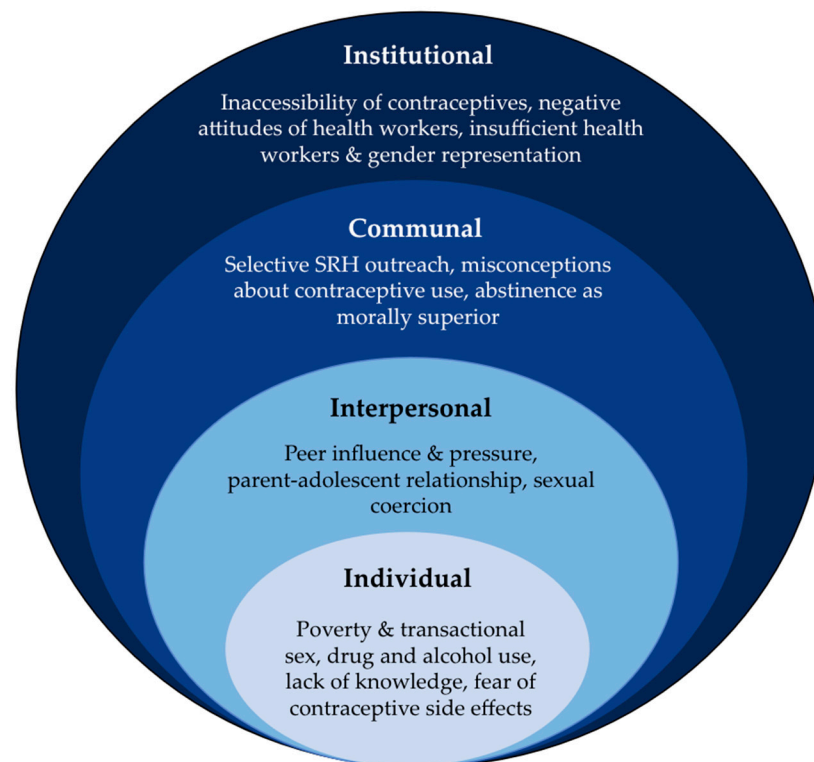


Figure 1. Socio-ecological model of sociocultural barriers influencing unplanned pregnancy among adolescents in the Mugombwa refugee camp, Rwanda.

3.3. Individual-Level Factors

At the individual level, four major themes arose: (1) poverty and transactional sex, (2) drug and alcohol use, (3) lack of knowledge about contraceptives, and (4) fear of contraceptive side effects.

3.4. Poverty and Transactional Sex

Adolescents overwhelmingly described how poverty challenges the lives and decisions of adolescents. Participants specifically described a causal model of how poverty contributes to the high prevalence of transactional sex, which is frequently accompanied by unplanned pregnancies. Transactional sex was spoken of as a necessity to meet an adolescent's basic needs:

"You may be at home with a problem of poverty that you feel will be solved if you go into prostitution. You feel like that bad idea will help you to have a better tomorrow."

(15–19 years old girl)

"Most of the difficulties that people of our age encounter in our community is poverty. Sometimes you can find your family being poor and not having the ability to afford all your needs and this leads to prostitution. This bad thinking and decision can ruin your future."

(15–19 years old girl)

The other side of the conversation on the prevalence of transactional sex also highlighted how adolescents not only use transactional sex for basic needs but also as a source of income to have the freedom to satisfy the desire to have materialistic pleasures. While this was not a pervasive narrative, some participants explained that their peers feel hopeless in the camp setting.

3.5. Drug and Alcohol Use

Participants identified the connection between the use of drugs and alcohol and unplanned sexual behavior. They shared that drug and alcohol use influences risky sexual behavior use such as the non-use of condoms, which leads to unplanned pregnancies and HIV/AIDS.

"My point of view is that there are some girls from our age who get pregnant and are affected by HIV/AIDS due to using alcohol and drugs."

(10–14 years old girl)

The discussions revealed that adolescents perceive alcohol and drug use to be a gateway to unplanned pregnancies as a result of impaired judgment to protect oneself during intercourse. Participants also illustrated a connection between drug and sexual assault perpetrated by boys in their community. They shared that, when the boys take drugs, its effect on them could lead to nonconsensual sex on a female.

"Some of the boys involve or engage in taking drugs like Marijuana and many others. After using drugs many of them think that what is next is having sex. Sometimes this may result into rape or sexual exploitation. That is my personal view."

3.6. Lack of Knowledge about Contraception

A common theme among participants was the issue of lack of knowledge on SRH. Adolescents described a lack of knowledge and awareness on contraception to be a reason for the prevalence of unplanned pregnancies:

"Sometimes adolescents don't have enough knowledge on contraception and STIs. When they have bad habits of having sex, they may have early pregnancy or be STI positive."

(15–19 years old girl)

"Many adolescents don't have knowledge on sexual and reproductive health. They are sometimes ashamed of asking for information about that, thinking that people will laugh at them which leads them to do what they don't know."

(15–19 years old girl)

Participants described how, if adolescents had more knowledge about contraceptive use, for example, they would be able to prevent pregnancy better. In discussions about

condom use, participants commonly shared that adolescents do not know how to use condoms properly and therefore fear using them:

“Some people our age fear to use condoms on account of not having adequate knowledge about the use of them. They fear negative effects that may result from using a condom improperly.”

(10–14 years old girl)

Participants shared that having improved SRH knowledge and regular interaction with SRH information would enable them to better navigate their own SRH.

3.7. Fear of Contraceptive Side Effects

The fear of side effects was the most common reason adolescents shared for not using contraceptives. Participants shared how negative perceptions of contraceptive methods result in unprotected sex and unplanned pregnancy:

“Sometimes you feel like you want to have sex, but you immediately hear bad things about those contraceptive methods. You feel like you cannot use them. You choose to do unprotected sex and get pregnant. So, we need many people who come to us for advice.”

(15–19 years old girl)

“We have been told that using IUD (intrauterine device) can bring negative effects to females. In addition to this, when a young girl engages in using contraceptive methods, this will cause ruin her life, and you may end up losing fertility. That is how I understand about that topic.”

(15–19 years old girl)

Adolescents explained that those who have a fear of side effects from contraceptives feel more comfortable using condoms, cycle tracking, or unprotected sex.

“As far as I am concerned, many girls don’t prefer to use implants and injections; instead, they prefer using condoms for the sake of avoiding unintended pregnancies as well as the sexually transmitted diseases.”

(10–14 years old girl)

“Some people in our community think that using IUDs can cause them to become sterile. Which is the inability to produce a child. Apart from that, the IUD can cause other serious problems. Another method that you didn’t mention is that girls should know how to count their monthly periods. This will help them to avoid unwanted pregnancies.”

(15–19 years old girl)

3.8. Interpersonal-Level Factors

At the interpersonal level, three themes were present: (1) peer pressure and influence, (2) sexual coercion, and (3) parent–adolescent relationships.

3.9. Peer Pressure and Influence

Adolescents’ peer groups and spheres of social influence frequently appeared throughout the discussions on sexual behavior. Adolescents described their peers as either major enablers or disablers of their sexual and reproductive health. While many adolescents reported their peers to be useful sources of their conversations about SRH, the majority of adolescents also stated that it was important for them to avoid negative peer influence to avoid sexual relations and unplanned pregnancy and to reach their dreams:

“Challenges people of my age or adolescents that we commonly face in our community is peer pressure. When those adolescents have bad friends, they sometimes engage in sexual relations. This contributes to the increase in the number of pregnancies in our community.”

(15–19 years old girl)

Respondents revealed the importance of peers in adolescent SRH wellness. While some adolescents cited their colleagues and friends as their major source of information, others spoke about the risks of their peer groups. Several participants described how boy peer pressure puts adolescent girls at a unique risk of unintended pregnancy by influencing boys to sexually coerce or rape girls:

“Based on what I see in our community, boys of our age are affected by peer pressure groups. In that group, some of them have girlfriends, and others don’t. Those who have girlfriends teach their colleagues some methods/techniques that they can use in order to be accepted. Some of them use alcoholic drinks as the best option of not being feared. Others advise them that if she refuses, take her by force. This will lead to impregnating that girl or getting HIV/AIDS. So boys have the problem of peer pressure.”

(15–19 years old girl)

3.10. Sexual Coercion

Participants, most notably between the ages of 15 and 19, also described the issue of sexual coercion in the context of intentional contraceptive misuse as a factor of unplanned pregnancy. Participants explained that boys coerce girls into having sex without a condom or purposely damage or manipulate condoms during sexual intercourse, which predisposes girls to unplanned pregnancies. One of the female participants explained:

“... There is a time when you can have sex with a boy thinking that you are using a condom while a boy has already made a hole at the head of the condom, aiming to impregnate that girl. So as girls, we have to make decisions for ourselves. About having sex, I still have enough time. It is better to do that with my own husband. About using condoms properly, it is better that a girl can be aware of checking if the condom is safe.”

(15–19 years old girl)

Participants felt that educating girls on sexual and reproductive health would protect them from contraceptive misuse.

3.11. Parent–Adolescent Relationships

Participants shared how the openness of communication between adolescents and parents about SRH topics is an important determinant of an adolescent’s SRH. Participants expressed that they feel most trusting of their parent’s ability to give them accurate and trustworthy information. However, adolescents shared that parents often avoid conversations about SRH with their children:

“Some of our parents when you ask them about sexual and reproductive health questions, they take you as a prostitute.”

(15–19 years old girl)

“For me, you can not engage yourself to ask something to your mom while she has never asked you to have conversations related to that topics. Some of us have the chance of having educated parents. When they are educated, they are aware of that and you can ask everything that you don’t know. But imagine having uneducated mom and you are willing to discuss with her about sexual activities topics. I think she cannot even allow you to discuss on that.”

(15–19 years old girl)

A prominent desire among adolescents was to have community health workers train their parents so that they could be able to actively participate in preventing unplanned pregnancies. An adolescent explained:

“I would recommend the health workers to talk to our parents so that they can spare time with their children in terms of talking to them about sexual reproductive health. This will reduce unintended pregnancies, the STI, and the HIV.”

(10–14 years old girl)

“My point of view, it could be better if the well-trained health workers from our community approach our parents and teach them how useful it is to talk to their kids about sexual reproductive health. This is because many adolescents at our age get pregnant, and I think this is because many parents in our community don’t spare time with their kids in teaching them about sexual reproductive health.”

(10–14 years old girl)

3.12. Communal-Level Factors

At the communal level, three themes emerged: (1) selective SRH outreach, (2) misconceptions about contraceptive use, and (3) abstinence as morally superior.

3.13. Selective SRH Outreach

Participants, primarily in the 15–19 age group, shared that, while community health workers do some community SRH outreach, community health workers cater to pockets of the population and lack comprehensive coverage of the adolescent population. Adolescents explained that this leads to large pockets of the population without SRH knowledge:

“Sometimes the community health workers make injustice while choosing girls in our quarters. They are used to choosing the same girls while we have so many girls in our quarter. The rest of the other girls will never have that knowledge because they train the same ones.”

(15–19 years old girl)

“What can be changed in our community is that community health workers are so selective. This is where they always choose the same person on every training. I think they should take all the girls in our quarter.”

(15–19 years old girl)

Participants also expressed how younger adolescents are often left out of community health worker SRH outreach activities. Adolescents between the ages of 10 and 14 are not often thought of as being sexually active, but participants explained that some in the camp are, which predisposes them to unplanned pregnancies when they are not included in outreach:

“My opinion is that people under fourteen years old are neglected, and based on my experience, a large number of adolescents in Mugombwa refugee camp that are impregnated are those of fourteen. This should be changed, and take from ten years then above, because there are some girls who start their monthly period at twelve.”

(15–19 years old girl)

3.14. Misconceptions about Contraceptive Use

Condoms were the most widely discussed contraceptive method used among adolescents. However, several adolescents explained that there are general communal misconceptions about condoms that prevent adolescents from using protection during sex. A common belief shared among adolescents was that if a condom is used it will get lost inside the vagina:

“For me, the only thing I can share is that we need a lot of information about reproductive health so that you don’t get sick or get pregnant. Because sometimes we hear false information. For example, when a virgin uses a condom, that can get inside the sex. The injection also causes disease. In general, we need enough information on these things to teach our peers.”

(15–19 years old girl)

“... There are some girls or boys who decide not to use condoms during sex due to some speculations in our camp that say that once a condom is misused, it may stay in a girl's private part.”

(10–14 years old girl)

For some adolescents, the fear of misusing a condom renders unprotected sex more appealing than using protection.

3.15. Abstinence as Morally Superior

Adolescents shared that they believe abstinence is the superior method of contraception as compared to other hormonal contraceptives. Participants shared that abstinence is the surest and best way to avoid unintended pregnancies, HIV, and STIs. A participant explained:

“For me to reach out to my dream, I have to apply abstinence by avoiding unintended pregnancies.”

(10–14 years old girl)

“My recommendation is that; they can reinforce adolescents to have abstinence for themselves. If not possible they can then use condom. But the first is abstinence.”

(15–19 years old girl)

The primary belief in abstinence reveals itself as a deterrent to utilizing other contraceptive methods. Many adolescents only endorsed the use of contraceptives once abstinence failed. The use of contraception among adolescents was viewed as a result of failing to abstain. One participant narrated:

“The reasons why people with our age but different sex apply birth control it's because they fail with abstinence.”

(10–14 years old girl)

Failing to abstain was also referenced in a negative light as the result of not being able to control oneself. It was clear through the discussions that engaging in sexual intercourse as an adolescent is stigmatized based on the belief that abstinence is superior.

3.16. Institutional-Level factors

At the institutional level, three themes emerged: (1) inaccessibility of contraceptive services, (2) negative attitudes of health workers, and (3) insufficient health workers and gender representation.

3.17. Inaccessibility of Contraceptive Services

A common concern among adolescents was the location of SRH services. Adolescents explained that contraceptives are largely centralized in the health center, which prevents adolescents from accessing them due to the fear of communal judgment. A participant explained:

“I really feel like we must find people here in the camp who will go and talk to the youth every week. Because young people are afraid to go to the hospital. And questioning is important to us, and it makes them less likely to engage in sexual activity.”

(15–19 years old girl)

“According to me, people from our community are used to seeking condom services at our health center. It could be better if condoms are distributed in public bathrooms so that they can be available for those people who feel uncomfortable to get them at our health center.”

(10–14 years old girl)

When asked if some adolescents feel ashamed asking for contraceptives, one participant said:

“Yes, there are so many. This is where people laugh at me, imagine at my age asking for a condom. It's better for us to put condoms on toilets where we will get it freely.”

(15–19 years old girl)

“When you are a girl and using the method of counting the days [of your menstrual cycle] will also help you. This can help you without asking for those services. You can do it for yourself.”

(15–19 years old girl)

Overwhelmingly, participants shared their desire to have a private, youth-specific space to discuss SRH issues and access contraceptive services privately without the fear of judgment from other community members.

3.18. Negative Attitudes of Health Workers

When adolescents spoke about their access to SRH services, they spoke about the large role that health professionals play in the dissemination of information and services. However, adolescents expressed that they have experienced judgment and unwelcoming responses from health professionals in response to their use of services, which hinders their access to SRH services:

“There are some service providers whom you tell your problem to, and they laugh at you. After that, you decide to never tell them all your problems.”

(15–19 years old girl)

“There is a time when you ask someone a question, and they reply ‘why are you asking that question’? When you ask someone, and they tell you that, you immediately feel like you will never go back.”

(15–19 years old girl)

Adolescents explained their need for receptive health professionals who are comfortable speaking about SRH topics to adolescents.

3.19. Insufficient Health Workers and Gender Representation

In addition to a lack of positive regard, participants explained that health professionals are often not present or available in the health center due to large demand. They explained how even singular negative experiences with this act as a barrier for them from utilizing the services in the future. One participant explained:

“I feel maybe you are going to ask someone a question. You find that he/she has a lot of things, yet you want a quick answer. When you go and ask him, there are times when he is talking to many people.”

(15–19 years old girl)

A solution many adolescents offered to address the issues they have experienced with health professionals is to expand the team of community health workers capable of responding to the needs of adolescents:

“My point of view, it would be better if our health center increases the number of nurses. I realized that a person may go to seek health services at a hospital, and it takes time to be hosted due to a big number of people who come to seek different services at the hospital. In addition, it would also be supportive if the number of health workers increases as well.”

(10–14 years old girl)

The majority of 10–14-year-olds expressed their appreciation for the value community health workers bring to adolescents who need information to avoid pregnancy.

“There is a time when a girl does sex, and she doesn’t get pregnant because of the advices obtained from a well-trained health worker. Mostly our health workers are used to counseling about how to avoid unintended pregnancies and the sexual transmitted diseases through using condoms.”

(10–14 years old girl)

Participants expressed that not only is an increase in the number of community health workers needed, but a health workforce composition with adequate gender representation is necessary to allow both males and females to comfortably access care and ask sensitive questions:

“In Mugombwa Health Center there is a lady called PELAGIE who is providing good services for adolescents. Myself and my colleague wish to have many as that lady. I think adolescents of Mugombwa refugee camp need people like her, she is flexible and we benefit more from her. So it’s better to bring more females than men. Because adolescents are more flexible when they are being advised by ladies. Of course, when he is a man, we don’t feel comfortable asking some questions. We sometimes become ashamed for asking some questions.”

(15–19 years old girl)

4. Discussion

This qualitative study sought to grant female adolescents epistemic authority to narrate their experiences and perceptions concerning unplanned adolescent pregnancy in the Mugombwa refugee camp in Rwanda. Each year, several dozen adolescents fall pregnant in the Mugombwa refugee camp. The findings present important insights into the sociocultural barriers influencing unplanned adolescent pregnancy at four socio-ecological levels: individual, interpersonal, communal, and institutional. Each year, several dozen adolescents experience unplanned pregnancies in the Mugombwa refugee camp, which imposes massive effects on their health, economic stability, school status, and future trajectory [21,23,24,29,32].

Adolescents painted a glaring picture of how poverty influences adolescent girls’ decision to engage in transactional sex. Most of the narratives appeared to indicate that transactional sex was used to compensate for a lack of access to basic needs. Several other studies, including some in Rwanda, have highlighted the presence of transactional sex and sexual violence in refugee settings in exchange for food, menstrual hygiene products, money, and other goods [13,15,33,34]. The body of literature echoes how poverty influences the acquisition of unplanned pregnancies, STIs, and HIV through prostitution [32,35,36]. These findings demonstrate how poor socio-economic status directly predisposes adolescents to sexual abuse and unplanned pregnancy. In Rwanda, the age of consent for sex is set at 18 years of age, whereas the age of marriage is 21. The age of consent for sex has a close-in-age exception for consensual sex between two adolescents above the age of 14 and below the age of 18 [37]. The Rwandan law criminalizes forced prostitution, trafficking, and exploitation of others. Law No. 51/2018 defines sexual exploitation as “the obtaining of financial or other benefits through the involvement of another person in prostitution, sexual servitude or other kinds of sexual services, including pornographic acts or the production of pornographic materials” [38]. Article 12 of the same Law No. 51/2018 also establishes special assistance to the child victim [38]. Subjecting children to prostitution is also an offense under the Law Regulating Labour No. 13/2009 [39]. Although the UNHCR sets standards to prevent sexual abuse of minors in refugee settings for organizations working with this key population that seek to implement different components of child protection mechanisms, including appointment and training of child protection officers, child-friendly reporting mechanisms, response and support services, and an accountability mechanism for perpetrators, the efficacy of these mechanisms within the Mugombwa refugee camp is not well understood [40]. Furthermore, access to comprehensive services for survivors of gender-based violence is only via a “One-Stop” center at a district-level hospital that is located 20 km outside of the Mugombwa refugee camp [41]. Our results highlight that adolescents do not perceive prostitution as child sexual abuse, but rather as a means to acquire their basic needs within the refugee camp. The availability of economic opportunities is a strong determinant of engagement in transactional sex [10]. Therefore, there is a strong need to inject robust income-generating activities in the camp as well as comprehensive education around sexual consent, exploitation, coercion, and child

sexual abuse, and systematized measures that safeguard refugees from sexual violence and effective early intervention and therapeutic healing opportunities.

Drug and alcohol use was also identified in our results and in the literature as a risk factor for sexual violence and unplanned pregnancy [36]. A sense of hopefulness about life's trajectories significantly impacts drug and alcohol use and sexual behavior. A study on the psychosocial indicators of adolescent risk behaviors showed that adolescents with higher perceived social mobility were less likely to report alcohol consumption and engagement in compensated sex and they were more likely to use a condom during sexual intercourse [42]. The hopelessness and lack of perceived social mobility that a refugee setting can confer for adolescents is an important area of further research and intervention to prevent drug and alcohol abuse, transactional sex, and risky sexual behavior. It is therefore crucial that research and interventions consider the intersectionality of an adolescent who is also a refugee since adolescent refugees experience more transient social statuses, which predisposes them to greater risk factors for unplanned pregnancy [8,10–12,16–18,24].

This study also demonstrated the important role of parents in adolescent SRH and preventing unplanned pregnancies. Adolescents reported that their parents are their most trusted sources of SRH information and advice. Similar studies in other humanitarian settings have shown similar findings that mothers and fathers are a significant source of SRH information [43–45]. Furthermore, other research points to poor parent-child communication regarding SRH matters as an interpersonal barrier to accessing contraceptives [46]. A major recommendation among adolescents was to have community health workers train their parents so that parents are equipped with more information on SRH to educate their adolescents. The literature supports this recommendation, showing that open discussion about SRH topics between parents and adolescents positively influences adolescents' perceptions and sexual behavior [36,46,47].

Furthermore, participants described the issue of negative peer influence and a wealth of unreliable information from peer groups that contribute to poor sexual choices and unplanned pregnancies. Consistent with our findings, several studies have also shown how an adolescent's social environment, specifically peers, greatly influences contraceptive utilization [48–50]. Peers can therefore serve as promising champions of SRH change. Future SRH outreach in the Mugombwa Camp may consider tapping into this powerful communication channel between peers to target contraceptive awareness raising.

The results of our study show that adolescent females have inadequate exposure and access to sexual and reproductive health information, especially as it pertains to contraceptive use. The literature corroborates our finding that adolescent girls frequently lack SRH information [43]. Myths and misconceptions about contraceptives proved to be a large communal barrier to contraceptive utilization. Poor knowledge of contraceptive use influences myths and misconceptions about contraceptives and unprotected sex [48,51,52]. Furthermore, research has shown that knowledge of contraceptive use greatly influences its utilization [48,53]. Our findings indicate an urgent need for regular training on how to use contraceptives to mitigate unplanned pregnancies. Furthermore, participants explained how adolescents commonly fear side effects associated with hormonal contraceptive methods. This finding is similar to a large body of research in several regions that have also shown that fear of side effects is one of the leading barriers to using hormonal contraceptive methods [33,52,54,55]. The fear of side effects, as highlighted by our results, is the result of both colloquially inherited myths and personal experience. Fear of side effects is largely analyzed in the literature from the lens of misinformation [33,56]. However, personal narratives and scientific literature demonstrate the pervasiveness of side effects from hormonal birth control [33,55,56]. These findings highlight the need to use informed consent by expanding education on the mechanisms of contraceptive action and providing accurate information on both the possible side effects and benefits of available methods during contraceptive counseling.

Our findings also highlight disparities in access to SRH information among adolescents. The participants explained that SRH outreach is selective to only certain sections of the

camp quarters and frequently neglects 10–14-year-olds. The younger adolescent age group is frequently neglected in SRH programming [57]. Although our findings did not focus on macro-level political factors, the Rwandan laws and policies on refugees do not address how age and gender impact access to opportunities and the well-being of adolescents [58,59]. Policies without an intersectional lens create gaps in the solutions they inform in addressing the diverse needs of adolescents in the Mugombwa camp itself [58]. In the Mugombwa refugee camp, the information, education, and communication (IEC) materials used to sensitize younger adolescents between the ages of 10 and 14 on SRH are produced by the Rwanda Ministry of Health (MOH). Currently, IEC materials for 10–14-year-olds only contain information on puberty, menstruation, and available SRH services, excluding information on contraceptive use, which the older adolescents' IEC materials contain [60]. Furthermore, the situational analysis guiding Rwanda's 2018 Family Planning and Adolescent SRH policy strategic plan, which was led by the MOH, does not include gaps faced by adolescents living in refugee camps, nor does it include the needs of 10–14-year-olds [59]. The poor inclusion of adolescent refugees and younger adolescents in this policy may limit the development of IEC materials used to sensitize younger adolescents in the Mugombwa refugee camp. This gap may contribute to the increase in teenage pregnancy among younger adolescents in the camp. More than one-third of births to mothers younger than 15 in developing countries are unplanned [5]. It is important that all stakeholders involved in adolescent SRH in the refugee camp setting ensure the full involvement of younger adolescents in the planning and implementation of SRH programs.

At the institutional level, negative attitudes of health workers and minimal health workforce capacity were prominent barriers to accessing and utilizing contraceptives. It is well understood in the literature that shame, stigma, and judgmental attitudes of health workers towards adolescents predict low SRH service utilization, including contraceptives [36,54,61,62]. Creating a safe and welcoming environment for adolescents significantly contributes to their acceptability and accessibility to SRH services. Adolescents also recommended increasing the number of health workers so that adolescents have a variety of individuals they can approach whom they are comfortable with. In the Mugombwa refugee camp, there are approximately 23 community health workers (CHWs) for the entire camp, and each focuses on a specific issue within the camp, whether that be sanitation, maternal health, HIV, etc. [41]. The absence of specific adolescent SRH outreach by CHWs could explain the gap adolescents have expressed. There is a need to assess the human health resource capacity within the camp to ensure that there are adequate numbers of health professionals available to conduct outreach comprehensively on SRH topics.

While sexual and reproductive health services are vital to preventing unplanned pregnancy among adolescents in the Mugombwa refugee camp, our findings demonstrate that sociocultural factors at each socio-ecological level underpin adolescent sexual behavior despite the provision of these services. Adolescents' main recommendations were to have a private, youth-friendly space, bolster health worker capacity in the camp, and train adolescents and parents regularly on SRH topics. These recommendations align with other literature on adolescent service utilization that shows that adolescent-friendly spaces, peer workers, school-based activities, and involving young people in programming increase intervention utilization [63]. Each of these recommendations offers an opportunity to improve the accessibility, acceptability, adequacy, and appropriateness of SRH services for adolescents in the Mugombwa camp to prevent unplanned pregnancy.

The risk factors surrounding adolescent females in a refugee setting cannot be discussed independently of gendered roles that influence each socio-ecological layer and the power dynamics that subject adolescent females to sexual violence and unplanned pregnancy. While this study sought to centralize the voices of female adolescents to grant them epistemic authority, our results also have the potential to overstate the control and power they have over their decision making. The refugee setting and pervasive cultural and gender norms often confer female adolescents with a lower social status, lack of decision-

making autonomy, dependency on men, and vulnerability to gender-based violence [7]. In other words, female adolescents are not inherently vulnerable unless the socio-ecological conditions and instability in refugee settings permit that vulnerability. Our results in the context of the socio-ecological model demonstrate how the agency and decision making power of female adolescents is complexed by social and political forces that supersede individual health behavior and hinder the sexual and reproductive agency of adolescent females [64].

5. Study Limitations and Strengths

This study faced some challenges and limitations. Language differences between the principal investigators, study participants, and enumerators limited the data quality checks performed during and after data collection. The selection criteria for participants were purposive and information was self-reported, which could have led to information bias. This study could have also been affected by social desirability bias due to the focus group environment. Given the potentially sensitive nature of this topic, participants may have responded with answers to appeal to the moderator or peers. This study's findings are also not generalizable to all adolescent experiences within the Mugombwa refugee camp, nor in other refugee camps in or out of Rwanda. Focusing our sampling strategy on adolescents in school was also a limitation of this study, however, since the refugee camp is a well-defined cohesive setting with internal migration, adolescents whether in or out of school are likely exposed to many different experiences that inform their perspectives as it relates to teenage pregnancy. In this study, we centralized the voices of female adolescents to grant them epistemic authority surrounding the narratives on unplanned pregnancy. Therefore, this study did not take into account the perspectives of other individuals who play a role in the issue of unplanned pregnancy such as parents, camp stakeholders, partners, health workers, government officials, etc. Although there may have been enablers present within the camp to prevent teenage pregnancy, our study solely focused on examining the barriers that contribute to an unplanned pregnancy.

Despite its limitations, the main strength of this study is its focus on centralizing the voices of female adolescents who live within the vulnerable context of the refugee camp. This approach not only expands our understanding of the challenges faced by these often-neglected groups living in refugee camps but also has the potential to inform policy and program development that offers superior support to this population. Additionally, centering the voices of themarginalized or overlooked is an important step toward achieving greater equity and social justice.

6. Recommendations

Our recommendations seek to transform the power relations and systemic facilitators of gender inequalities within the Mugombwa refugee camp to reduce unplanned pregnancy using the socio-cultural barriers that emerged from this study. The results of this study demand a holistic model of sexual and reproductive health that addresses social determinants of adolescent pregnancy. We recommend that interventions and policies aim to improve the capacity of health professionals to deliver contraceptive services, involve adolescents and parents as principal stakeholders in program design and implementation, and target SRH outreach specifically to “invisible groups” such as those between the ages of 10 and 14. Furthermore, an analysis of the responsiveness of UNHCR child sexual abuse policies merits further investigation to modify or design interventions including community health workers, men, and boys to prevent, intervene, and respond to adolescent sexual abuse. Interventions aimed at engaging men and boys to promote SRH services use should also be designed and implemented in the refugee camps.

In the future, there is also a need to explore the SRH needs of people with multiple marginalized identities such as those with disabilities, and male adolescents within the camp setting. Additionally, further exploration is needed on the efficacy of SRH sensi-

zation and information delivery mechanisms within the camp to establish more rigorous channels of communication about SRH topics to adolescents.

7. Conclusions

This study provides insights into the SRH experiences of adolescent girls living in the Mugombwa refugee camp in Rwanda. Its findings present an understanding of the sociocultural barriers contributing to unplanned pregnancies among adolescents. Despite the provision of SRH services in the camp, adolescent females experience context-specific barriers to accessing SRH services on the individual, interpersonal, community, and macro-social levels. The adolescents' main recommendations for improving SRH services for adolescents were to offer youth-specific services outside of the health center, increase the regularity of SRH training, increase health worker capacities, and train parents and youth as SRH stakeholders. Our findings demonstrate that SRH interventions must address these socioecological determinants to robustly protect adolescent sexual and reproductive health.

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