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Drivers of Adolescent Pregnancy Among Girls Aged 14-17 Years in Kirehe District, Rwanda: A Qualitative Study of Community and Stakeholder Perspectives

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Abstract: Adolescent pregnancy is increasing in Rwanda. The proportion of girls aged 15-19 years who have ever been pregnant rose from 5% in 2019-20 to 8% in 2025, and the Eastern Province is among the most affected areas. This study explored community and stakeholder perspectives on the factors contributing to pregnancy among girls aged 14-17 years in Kirehe District and on the barriers to its prevention. An exploratory qualitative design guided by the socio-ecological model was used. Data were collected in 2026 through 19 key informant interviews with health care providers, community health workers, teachers, parents, teen mothers, a student and a religious leader, and six focus group discussions with 25 participants. Data were analysed thematically using NVivo 14. Five themes were identified: disapproval of early pregnancy and silence about sexuality; peer influence, alcohol, night parties and social media; poverty, school dropout and sexual exploitation; knowledge of contraception without use; and limited access to youth-friendly services. Early pregnancy was viewed as unacceptable, but parents rarely discussed sexuality with their daughters and adolescents hid their relationships. Participants reported that sexual activity often starts at 12-15 years. Poverty, school dropout and sexual abuse by adults, including some community leaders, increased girls' vulnerability. Adolescents knew about contraception but rarely used it, mainly because they feared being called sex workers. Youth corners were far from many villages, often understaffed and sometimes judgemental. The study recommends parent-adolescent communication programmes, school retention, community-based youth-friendly services and strict enforcement of laws against child defilement.

Keywords: *Adolescent Pregnancy, Teenage Pregnancy, Qualitative Research, Socio-Ecological Model, Parent-Adolescent Communication, Youth-Friendly Services, Contraception, Rwanda.*

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I. INTRODUCTION

Adolescent pregnancy is a major public health and development concern in low- and middle-income countries (LMICs). The World Health Organization (WHO) estimates that girls aged 15-19 years in these countries have about 21 million pregnancies each year. About half of these pregnancies are unintended, and they result in about 12 million births [1]. Adolescent mothers have higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20-24 years, and their babies have higher risks of low birth weight and preterm birth. Early pregnancy also often ends a girl's education and limits her future economic opportunities [1]. Sub-Saharan Africa has the highest burden. Systematic reviews from the region have associated adolescent pregnancy with poverty, school dropout, peer influence, substance use, unwanted sexual advances from adult men, poor parent-adolescent communication and limited access to contraception [2], [3].

Rwanda has made important progress in maternal and child health, but adolescent pregnancy has increased in recent years. The 2025 Rwanda Demographic and Health Survey (RDHS) found that 8% of women aged 15-19 years had ever been pregnant, compared with 5% in 2019-20. The proportion increased from less than 1% at age 15 to 20% at age 19 [4], [5]. Adolescents in the Eastern Province and in the poorest households start childbearing earlier than others, and contraceptive use is lower among women aged 15-19 years than in any other age group [4]. Studies using national survey data have associated teenage pregnancy in Rwanda with individual, household and contextual factors, including age at sexual debut, parental education and non-use of contraception [6], [7].

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The Government of Rwanda has responded through the National Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan, youth corners in health centres, school-based sexuality education and community-based family planning delivered by community health workers (CHWs) [8]. In 2025, Law n° 026/2025 regulating healthcare services set 15 years as the age at which a person can consent to health care. This allows adolescents aged 15 years and above to access contraception and other sexual and reproductive health (SRH) services without parental consent [9]. However, the success of these measures also depends on families, peers, schools, communities and health services.

Some qualitative studies in Rwanda have examined these influences. Secondary school students in the Eastern Province reported that the lack of parental guidance on sexual matters was a major barrier to preventing unwanted pregnancy [10]. Teen mothers have reported stigma, household-based health insurance rules and financial difficulties when seeking care [11]. Studies in Mahama refugee camp, which is located in Kirehe District, described stigma, isolation and the concealment of paternity among pregnant adolescents [12], [13]. A survey of health and social service providers found that adolescent SRH services were available in many facilities, but family members and religious leaders often discouraged adolescents from using them [14]. However, few studies have combined the views of the different community members who interact with girls aged 14-17 years in rural districts. Kirehe District is a largely rural district bordering Tanzania. According to district Health Management Information System (HMIS) records, 360 girls aged 14-17 years became pregnant in the district in 2025 [15].

This study explored how community members and stakeholders in Kirehe District understand the factors that lead to pregnancy among girls aged 14-17 years, the barriers to prevention and the solutions they propose. The analysis was guided by the socio-ecological model, which explains health behaviour as the result of influences at the individual, interpersonal, community, institutional and policy levels [16], [17]. This paper presents the qualitative component of a larger mixed-methods study. The survey findings are reported separately.

II. METHODOLOGY

➢ *Study Design*

An exploratory qualitative design was used to obtain the views of people who live and work closely with adolescent girls. The study was the qualitative component of a cross-sectional mixed-methods study on factors associated with adolescent pregnancy in Kirehe District. Quantitative and qualitative data were collected at the same time and analysed separately. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were used to guide reporting [18].

➢ *Study Setting*

The study was conducted in Kirehe District, one of the seven districts of the Eastern Province of Rwanda. The district is mainly rural, and most people depend on agriculture and small-scale trade. Primary health care is provided through health centres, many of which have youth corners for adolescent SRH services, and through village-based CHWs who provide health education and community-based family planning.

➢ *Participants and Sampling*

Participants were selected purposively because of their knowledge of adolescent girls and pregnancy prevention in the district. Key informants included nurses and other health care providers (among them an adolescent sexual and reproductive health (ASRH) focal person and an ASRH officer), CHWs, teachers, parents, teen mothers, a female student and a religious leader. Separate focus group discussions (FGDs) were held with six groups: CHWs, health care providers, teachers, teen mothers, parents and religious leaders. Health centre staff, school leaders and village leaders helped to identify participants and were asked not to put pressure on anyone to participate. Data collection continued until no new themes emerged, following the principle of data saturation [19]. In total, 19 key informant interviews (KIIs) and six FGDs with 25 participants were conducted.

➢ *Data Collection*

A semi-structured guide was developed from the study objectives and the literature. It included questions on community views of early pregnancy, the expected age at marriage and childbearing, age at first sexual activity, peer and parental influences, adolescents' knowledge of SRH services and contraception, access to youth-friendly services, social, cultural and economic barriers, personal experiences and recommendations. The same guide was used for KIIs and FGDs, with probes adapted to each group. The tools were pre-tested in Ngoma District, a neighbouring district with similar characteristics, and revised for clarity. Interviews and discussions were conducted in Kinyarwanda in private settings in April 2026. They were audio-recorded with permission, and the interviewers also took field notes. Each KII lasted about 45 to 60 minutes. Recordings were transcribed and translated into English for analysis.

➢ *Data Analysis*

Transcripts were imported into NVivo version 14 and analysed using the six phases of thematic analysis described by Braun and Clarke, namely becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the report [20]. Coding was both deductive, based on the levels of the socio-ecological model, and inductive, based on new ideas raised by participants. KII and FGD data were first coded separately and then compared across methods and participant groups. The coding framework and themes were reviewed with the research supervisor, and differences were resolved through discussion. The number of KIIs and FGDs in which each sub-theme was mentioned was recorded to show how widely it was shared (TABLE II). These counts are descriptive only. Quotations are labelled with the data source and the participant's role, sex and age. Minor grammar and spelling corrections were made, and added words are shown in square brackets.

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➢ *Trustworthiness*

Credibility was strengthened by comparing data from two methods and seven participant categories and by checking preliminary interpretations with some participants. An audit trail of coding decisions and analytic notes supported dependability and confirmability, and a description of the setting and participants was provided to support transferability [21].

➢ *Ethical Considerations*

Ethical approval was obtained from the Mount Kigali University Ethical Review Board (Ref. MKUR04/ERC/0911, 19 March 2026). Permission was also obtained from Kirehe District Hospital and local administrative authorities. Adult participants gave written informed consent. For participants younger than 18 years, a parent or guardian gave written consent and the adolescent gave assent. Participants who could not read gave verbal consent in the presence of an impartial witness. Participation was voluntary, interviews were held in private, names were removed from transcripts, and data were stored on password-protected devices. Participants who became distressed could be referred to counselling and psychosocial support services in the district.

III. RESULTS

➢ *Characteristics of Participants*

Nineteen key informants participated (TABLE 1). Twelve were women and seven were men, and their ages ranged from 19 to 62 years (median 40 years). They included five health care providers, five parents, three teachers, two CHWs, two teen mothers, one student and one religious leader. Six had primary education, six had secondary education, one had an advanced diploma and six had a university degree. The six FGDs included 25 participants from six groups: CHWs, health care providers, teachers, teen mothers, parents and religious leaders.

Table 1 Characteristics of Study Participants

Characteristic	Category (n)
Key informant interviews (n = 19)	
Sex	Female (12); male (7)
Age (years)	19-29 (6); 30-49 (7); 50-62 (6); median 40, range 19-62
Education	Primary (6); secondary (6); advanced diploma (1); university (6)
Role	Health care providers, including nurses and an ASRH officer (5); parents (5); teachers (3); community health workers (2); teen mothers (2); student (1); religious leader (1)
Focus group discussions (6 groups, 25 participants)	
Groups	Community health workers; health care providers; teachers; teen mothers; parents; religious leaders (one group each)

ASRH: Adolescent Sexual and Reproductive Health.

➢ *Overview of Themes*

Five themes were identified, covering all levels of the socio-ecological model (TABLE 2 and Fig. 1). These were (1) disapproval of early pregnancy and silence about sexuality, (2) peer influence, alcohol, night parties and social media, (3) poverty, school dropout and sexual exploitation, (4) knowledge of contraception without use, and (5) limited access to youth-friendly services. Participants described these factors as connected to one another.

Table 2 Themes, Sub-Themes and Socio-Ecological Levels

Theme	Sub-theme	Level	KIIs (n = 19)	FGDs (n = 6)
1. Disapproval of early pregnancy and silence about sexuality	Early pregnancy seen as shameful and a sign of failed parenting	Community	19	6
	Sexuality treated as taboo; adolescents conceal relationships	Family, community	13	5
	Weak parental supervision and guidance	Family	16	5
2. Peer influence, alcohol, night parties and social media	Peer pressure and misinformation	Interpersonal	19	6
	Alcohol, drugs and night parties	Interpersonal, community	15	6
	Social media and aspirations for a “better life”	Interpersonal, individual	9	3
3. Poverty, school dropout and sexual exploitation	Poverty and transactional sex	Structural	17	4
	School dropout and lack of alternatives	Structural, institutional	13	6
	Sexual exploitation by adults, GBV and unreported rape	Community, structural	10	3
4. Knowledge of contraception without use	Partial and uneven knowledge of SRH and contraception	Individual	12	4

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	Awareness without use; myths and religious or cultural objections to contraception	Individual, community	11	5
	Fear of being labelled a sex worker or judged	Community, individual	17	6
5. Limited access to youth-friendly services	Understaffed or irregular youth corners	Institutional	8	3
	Distance and concentration of services at health centres	Institutional	12	6
	Judgemental provider behaviour and lack of privacy	Institutional	12	5
	Enablers: free services, delivery by CHWs, proximity	Institutional	6	1

KII: key informant interview; FGD: focus group discussion; GBV: gender-based violence; SRH: sexual and reproductive health; CHW: community health worker. Counts are the number of KIIs and FGDs in which each sub-theme was raised.

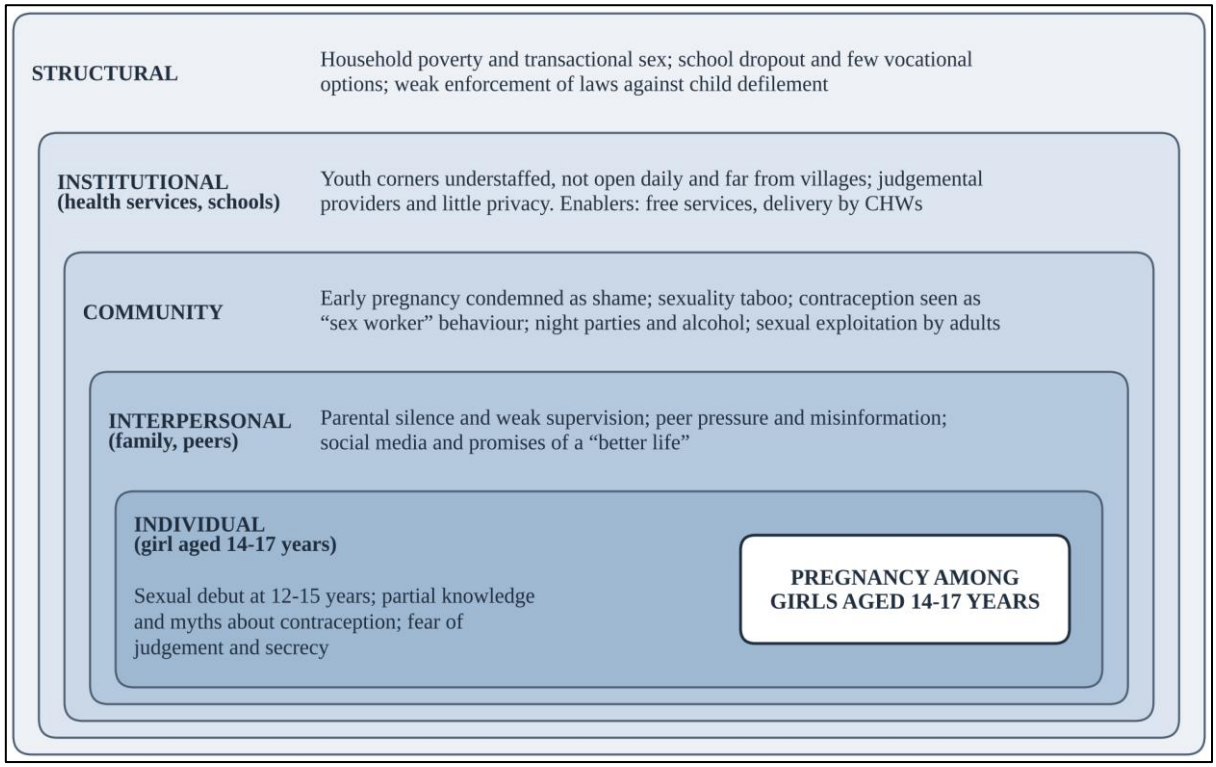


Fig 1 Socio-Ecological Map of the Factors Driving Pregnancy Among Girls Aged 14-17 Years in Kirehe District

➢ *Theme 1: Disapproval of Early Pregnancy and Silence about Sexuality*

All key informants and FGDs described early pregnancy negatively, either as unacceptable or as a sign of moral or parental failure. Participants reported that the expected age for marriage or childbearing in their community was between 18 and 25 years, most often 21 or 22 years. None of them described early marriage as a community expectation. Early pregnancy was seen as a failure of the girl and her family. A nurse described the community view as *"Failure in parenting, prostitution"* (KII-03, nurse, female, 40 years). Another nurse explained that when a girl becomes pregnant, *"they start to harass her"* (KII-02, nurse, male, 26 years).

Despite this disapproval, sexuality was rarely discussed in families. Thirteen key informants and five FGDs described sexuality as a taboo subject and said that adolescents hide their relationships because they know their parents disapprove.

"Talking about sexual reproductive health with children is taboo in our community." (KII-11, parent, female, 50 years)

"Teenage[rs] hide their perception about sexuality; having sex before marriage is like prohibited by parents." (FGD-2, health care providers)

"Adolescents hide their sexual activities [from] the parents as it is not acceptable." (KII-17, religious leader, male, 55 years)

Some adult participants had the same experience when they were young. A teacher said, *"Parents did not educate me about reproductive health. I was shocked by first menses"* (KII-09, teacher, female, 28 years). Weak parental supervision was mentioned in 16 KIIs and five FGDs. Parents were described as spending little time with their children: *"Parents do not take time with their children and leave them to peers who influence them"* (FGD-5, parents). Teen mothers

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reported that only health care providers helped adolescents and that *"parents do not [help]"* (FGD-4, teen mothers). Participants agreed that communication with parents protects adolescents: *"When parents talk to their children it addresses the problem. But when they don't, it exacerbates the problem"* (FGD-1, CHWs).

- *Theme 2: Peer Influence, Alcohol, Night Parties and Social Media*

Participants estimated that girls in their communities start sexual activity between 12 and 15 years of age, most often at 13 or 14 years. All key informants and FGDs mentioned peers as an influence on early sexual activity, although one young participant felt that peers mattered only *"to some extent"* (KII-10, student, female, 20 years). Peers were described as a source of wrong information (*"By sharing false or incomplete information about sexual activity"*, KII-12, CHW, female, 40 years) and as encouraging girls to stay out late and attend places where sexual activity was likely. Alcohol, drugs and night parties were mentioned in 15 KIIs and all six FGDs.

"They influence them very much, through drinking alcohol and drugs. There are these night parties where the youth meet; most of them get [pregnant] in these parties." (KII-01, CHW, female, 38 years)

A teen mother mentioned *"coming home late, encouraging sexual activities, alcohol use"* as ways in which peers influence girls (KII-08, teen mother, female, 20 years). Social media and the wish for a better life were mentioned in nine KIIs and three FGDs. Participants described the misuse of social media as a risk behaviour and linked it to a desire for money, luxury and fame that peers encouraged.

"Bad use of social media, desire to be rich easier, desire to live in luxury, or to be celebrities." (KII-03, nurse, female, 40 years)

"They have a big influence, promising them a better life, being celebrities." (FGD-6, religious leaders)

- *Theme 3: Poverty, School Dropout and Sexual Exploitation*

Poverty was mentioned in 17 KIIs and four FGDs. Participants said that some girls from poor households engage in sexual relationships to get money, as in *"Poverty in families; some adolescents are engaging [in] sexual activities for money"* (KII-07, health care provider, female, 28 years) and *"Poverty makes adolescents engage in sexual activities"* (FGD-3, teachers). School dropout was mentioned in 13 KIIs and all FGDs, both as a cause and as a result of pregnancy. Participants said that girls who are out of school are at the highest risk (*"Children who are not in school are the most affected"*, KII-05, ASRH officer, male, 45 years). A teacher said, *"I have students leaving school because they are pregnant"* (KII-04, teacher, male, 51 years). The ASRH officer also mentioned *"house workers"*, alcohol consumption in the family and family conflicts as risk factors.

Participants also reported sexual exploitation of adolescents by adults. Ten key informants and three FGDs mentioned gender-based violence (GBV), rape that is not reported, or adults who have sex with children. In four KIIs and the teen mothers' FGD, participants said that some of the people who are expected to guide adolescents were themselves involved.

"Some of them [leaders, elders or religious figures] are the ones who have sex with adolescents and make them pregnant." (KII-11, parent, female, 50 years)

"Yes, some of them are involved directly in having sex with adolescents." (FGD-4, teen mothers)

A nurse described the barriers to prevention as *"poverty in families, GBV, not denouncing rape"* (KII-03). Participants in several groups asked for *"severe punishments to adults having sex with children"* (KII-15, parent, male, 60 years).

- *Theme 4: Knowledge of Contraception without Use*

Most participants believed that adolescents had heard about condoms, family planning, prevention of HIV and other sexually transmitted infections, and youth corners. However, this knowledge was often limited, especially among girls with little education. In 12 KIIs and four FGDs, participants said that many adolescents *"know little about reproductive health"* (FGD-3, teachers) or that *"most of them have no knowledge"* (KII-10, student, female, 20 years). Participants also said that adolescents who knew about contraception often did not use it.

"Yes, they are aware but they don't use them." (KII-01, CHW, female, 38 years)

"Some of them have knowledge, but don't use them because of misconception." (KII-17, religious leader, male, 55 years)

Reasons given for non-use included myths about contraception, religious teaching and cultural rejection of contraceptive use by unmarried girls (*"Stigma on contraception; cultural unacceptance of contraception"*, KII-07; *"Religious teachings prevent adolescents from using contraceptive methods, leading to unwanted pregnancies"*, KII-04). The most common reason was fear of being judged. Fear of being called a sex worker or prostitute, or of being judged in general, was mentioned in 17 KIIs and all six FGDs.

"Adolescents don't seek contraception services because they fear to be judged as sex workers." (FGD-4, teen mothers)

"Some do not understand contraceptive methods, especially [the] uneducated; others fear social stigma, to be called sex workers." (KII-03, nurse, female, 40 years)

This fear was closely related to the community disapproval described in Theme 1 and to the low use of services described in Theme 5.

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➢ *Theme 5: Limited Access to Youth-Friendly Services*

Participants knew that each health centre had a youth corner and that services were free of charge. However, most said that the services were difficult to use. Eight KIIs and three FGDs reported that youth corners were not open every day or that no provider was present when adolescents came.

"Youth corners are in each health center, but caregivers [are] not available every day due to [an] insufficient number of staff." (KII-03, nurse, female, 40 years)

"Lack of enough health care providers makes it difficult, as adolescents may come and don't find providers." (KII-07, health care provider, female, 28 years)

Distance was mentioned in 12 KIIs and all six FGDs, because services were mainly provided at health centres far from many villages: *"They are only found at [the] health center, which is far"* (KII-06, parent, female, 40 years). Provider behaviour and lack of privacy and confidentiality were mentioned in 12 KIIs and five FGDs: *"Some health care providers' behaviors prevent adolescents from accessing reproductive health services"* (FGD-5, parents). One parent added that *"some parents prevent them from seeking services"* (KII-18, parent, female, 62 years).

However, not all participants described access as difficult. Six key informants mentioned factors that made services easier to use, including free services, short distance (*"Near our village"*, KII-10) and services provided by CHWs in the community (*"When they are provided in the community by CHWs"*, KII-13, teacher, female, 43 years). The same teacher explained, *"For some it is easy to access, others not, depending on where they live"* (KII-13).

➢ *Recommendations from Participants*

Participants made recommendations related to the barriers they described. All KIIs and FGDs recommended that parents talk with and supervise their children, and parents said that they *"should know which group their children engage in"* (FGD-5, parents). Keeping girls in school, helping teen mothers return to school and providing vocational training to out-of-school adolescents were recommended in 14 KIIs and all FGDs. Other recommendations included providing services closer to the community through CHWs, youth corners in schools, village youth committees and trained youth leaders, and ensuring that providers do not judge adolescents. Participants also recommended severe punishment of adults who have sex with children (nine KIIs and one FGD), stricter control of alcohol use and night parties involving children (seven KIIs and two FGDs), community education to correct myths about SRH services, and poverty reduction and economic support for poor households and teen mothers.

IV. DISCUSSION

This study explored the factors that lead to pregnancy among girls aged 14-17 years in Kirehe District from the perspective of community members and stakeholders. Participants described several connected factors. These included disapproval of early pregnancy combined with silence about sexuality, weak parental guidance, peer influence, alcohol, night parties and social media, poverty, school dropout and sexual exploitation by adults, and services that adolescents know about but find difficult to use. These findings are consistent with the socio-ecological model [16], [17]. No single factor explained adolescent pregnancy, and factors at different levels influenced one another (Fig. 1).

An important finding was that strong community disapproval of early pregnancy was not accompanied by open communication about sexuality. WHO and much of the regional literature describe child marriage as a major cause of adolescent pregnancy [1], [22]. In Kirehe, however, participants expected marriage in the early twenties and described pregnancies that occurred outside marriage in hidden relationships. Disapproval did not appear to delay sexual activity. Instead, it led adolescents to hide their relationships, which made it difficult for them to seek advice from parents or to use contraception without being noticed. Similar findings were reported in Mahama refugee camp in the same district, where pregnant adolescents were seen as a shame to the community and concealed the identity of their partners [12], [13], and in secondary schools in the Eastern Province, where students reported a lack of parental guidance [10]. Reviews from sub-Saharan Africa show that parent-child communication about sexuality is often limited by cultural norms and, when it happens, mainly consists of warnings rather than information [23]. A similar pattern was reported in rural Tanzania [24]. Programmes that help parents to talk with their children about sexuality should therefore be prioritised. These programmes could use existing platforms such as parents' evening forums (*Umugoroba w'Ababyeyi*), CHWs and religious groups.

The influence of peers, alcohol and night parties is consistent with the review by Yakubu and Salisu, which identified peer influence and substance use as determinants of adolescent pregnancy [2]. Alcohol use is associated with sexual risk behaviour in sub-Saharan Africa [25], and the night parties described by participants combine peer pressure, alcohol and lack of adult supervision. Research on the effect of social media on adolescent sexual behaviour is still limited [26]. In this study, social media was linked to a desire for money and luxury, which may make girls more likely to accept transactional relationships. Community measures such as limiting children's access to alcohol and supervising youth gatherings could support education programmes for adolescents.

Poverty and school dropout were important underlying factors. This agrees with the meta-analysis by Kassa et al., which found that adolescent pregnancy in Africa was associated with being out of school, rural residence, low maternal education and lack of parent-adolescent communication on SRH [3]. The transactional relationships described by participants are similar to those reported in other studies in sub-Saharan Africa, where transactional sex is driven by both material need and the desire for consumer goods and status [27]. Evidence that cash transfers can keep

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girls in school and reduce early pregnancy and marriage [28], together with the 2025 WHO recommendations on education and economic empowerment [22], supports linking pregnancy prevention in Kirehe with social protection and education programmes. The reports of sexual exploitation by adults, including some community leaders, need particular attention. Sexual relations with a child are a crime of child defilement under Rwandan law [29], but participants said that rape is often not reported. Every pregnancy in a girl under 18 years should therefore lead to screening for abuse and, where needed, referral to Isange One Stop Centres, in addition to reproductive health care.

The gap between knowledge and use of contraception has been reported in other studies. Reviews from LMICs show that fear of social disapproval, misconceptions about side effects and fertility, and negative provider attitudes prevent adolescents from using contraception [30], [31]. In Kirehe, fear of being called a sex worker was one of the most common barriers, and it was linked to the same norms that discourage discussion of sexuality. This may explain why awareness campaigns alone have had limited effect. Prevention programmes also need to reduce the stigma attached to contraceptive use by unmarried girls. In Rwanda, contraceptive use protects against teenage pregnancy [6], but it remains lowest among women aged 15-19 years [4].

Participants reported that youth corners were understaffed, not always open, far from many villages and sometimes judgemental. Similar gaps have been reported in urban health facilities in Rwanda [14] and in Kenya [32]. A systematic review found that confidentiality, provider attitudes and convenient opening hours strongly influence whether adolescents use services [33]. The new law allowing adolescents aged 15 years and above to consent to health services removes a legal barrier [9], but its effect may be limited if girls cannot easily reach a provider who treats them without judgement. Participants suggested bringing services closer to adolescents through CHWs, youth corners in schools and village youth committees. Rwanda has CHWs in every village [34], and teen mothers have described CHWs as supportive [11]. CHWs could therefore provide confidential counselling and contraception to adolescents if they receive appropriate training. Girls aged 14 years are below the age of consent for health services and will still need support from trusted adults.

- *Strengths and Limitations*

This study included the views of seven groups of participants and used two data collection methods, which allowed comparison of findings. It was also conducted in a rural district where adolescent pregnancy is increasing. The study has some limitations. Girls aged 14-17 years were mainly represented by teen mothers and adults, so the views of younger adolescents may not be fully captured. Reports on sensitive issues such as sexual exploitation may be affected by social desirability or hearsay and could not be verified. Some responses were short, which limited the depth of analysis for some sub-themes, and some meaning may have been lost in translation from Kinyarwanda. The findings come from one district and should be applied to other settings with caution.

V. CONCLUSION

Pregnancy among girls aged 14-17 years in Kirehe District is caused by several connected factors. Community members and stakeholders reported that early pregnancy is strongly disapproved of, but sexuality is rarely discussed. As a result, girls start sexual relationships early and in secret, without the information, support or services they need to prevent pregnancy. Peer pressure, alcohol, night parties and social media encourage early sexual activity. Poverty, school dropout and sexual exploitation by adults increase girls' vulnerability. Fear of being called a sex worker, together with distant, understaffed and sometimes judgemental youth corners, prevents girls from using contraception even when they know about it.

Based on these findings, five actions are recommended for Kirehe and similar rural districts. Parent-adolescent communication programmes should help parents discuss sexuality with their children and supervise them, using existing platforms such as parents' evening forums, CHWs and religious groups. School retention, school re-entry for adolescent mothers and vocational training for out-of-school girls should be linked with social protection for poor households. Youth-friendly services should be brought closer to adolescents through CHWs, schools and village youth structures, with enough staff in youth corners and providers trained to offer confidential care without judgement, in line with the 2025 law on healthcare services. Community dialogue should reduce the stigma attached to contraception. Laws against child defilement should be enforced, including when the suspected offenders are community leaders, and every pregnancy in a girl under 18 years should lead to screening for abuse. Future studies should include girls aged 14-17 years directly and should evaluate community-based interventions that address several levels of the socio-ecological model.

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