

# FACTORS INFLUENCING TEENAGE PREGNANCY AMONG ADOLESCENTS ATTENDING ADOLESCENTS' CLINIC AT KALISIZO GENERAL HOSPITAL, KYOTERA DISTRICT IN UGANDA. A DESCRIPTIVE CROSS-SECTIONAL STUDY.

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## Abstract

### Background:

According to the United Nations Children Fund (UNICEF) defines teenage pregnancy as “a teenage girl usually within the age of 13 to 19 years, becoming pregnant and refers to girls who have not reached legal adulthood, which varies across the world.

### Methodology:

A descriptive cross-sectional one in which and quantitative method of data collection was used. The researcher utilized simple random sampling on 75 respondents from December 2022 to January 2023. The data collection process was for 10 days using self-administered questionnaires which were filled, cleaned, and later analyzed using tables.

### Results:

Out of the 75 respondents in the study, the majority 57(76%) of the respondents were between (17-18) years old, and 18(24%) of the respondents were between (13-16) years old. Low use of contraceptives was the most cause of teenage pregnancy by 69(92%), the findings revealed that 63(84%) had knowledge about the control of teenage pregnancy, Majority 41(65%) knew the use of condoms. Most of the respondents 68(90.67%) reported that teenage pregnancy affects one's academics as the major health impact.

### Conclusion:

According to the findings of the study, the most 69(92%) common cause of teenage pregnancy is low contraceptive use. Most 63(84%) female adolescents had good knowledge about control of teenage pregnancy, and 68(90.67%) reported that teenage pregnancy affects one's academics.

### Recommendations :

The researcher recommends that sex education be included in the curriculum of the primary and secondary schools. Adolescents-friendly services be instituted in Health facilities to health educate them on reproductive health services and counsel them on the dangers of premarital sex.

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## 1. Background of the study

According to Ochen et al, 2019, the United Nations Children Fund (UNICEF) defines teenage

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pregnancy as “a teenage girl usually within the age of 13 to 19 years, becoming pregnant and refers to girls who have not reached legal adulthood, which varies across the world (Ochen et al., 2019) The factors contributing to teenage pregnancy are multifactorial, ranging from individual-behavior, traditional, and socio-cultural to religious in nature. Inarguably, low socio-economic status, limited education, and early sexual activity can perpetuate teenage pregnancy. (KUP,2021)

Take care health stated that, Globally, the adolescent birth rate (ABR) has decreased, but rates of change have been uneven across regions. (WHO,2022) Approximately 15 percent of young women globally reported giving birth before age 18 from 2015-2020. This percentage, however, has been found to vary by a number of factors including the region, the country, the location within the country (rural vs. urban), and the young woman's levels of income and education. (UNICEF,2021).

As of 2019, adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended (WHO 2022).

In addition to that study, a study conducted by Magnusson in the USA in 2019 showed that a lack of parental support on adolescents' contraceptive use has been noted, the study also showed that young adolescents consider parents as mentors. They would prefer to get information from parents who use local languages compared to the use of medical words or professional terminologies (Dombola et al., 2019)

Nevertheless, research in the USA showed that communities do not create a conducive environment regarding contraceptive use among young adolescents. Male participants were concerned about communities not encouraging them to access contraceptives (Dombola et al., 2019). Participants in both male and female FGDs reported that society would not allow an adolescent to exercise his or her freedom and make an independent decision. (Dombola et al., 2019, Magnusone BM et al 2019)

Research carried out in Pakistan amongst women attending antenatal clinics in Pakistan

indicated that the use of contraception was low and the most commonly used being condoms (19%) followed by injectable (9.7%), pills (9.6%), intrauterine devices (2.9%), and implants (2.5%) while 13.8% and 46.1% women reported use of rhythm and withdrawal method respectively (Habib et al., 2017)

Furthermore, a study in sub-Sahara Africa the Perceived determinants of teenage pregnancies included; lack of knowledge on how to control pregnancy, low acceptance/use of contraceptives, neglect by parents, sexual abuse, pressure to contribute to family welfare through early marriage or sexual transactions, lack of community responsibility, media influence, peer pressure, cultural beliefs that promote early marriage/childbearing and lack of role models. The sub-Saharan Africa 28% of adolescents give birth before the age of 18. Twenty-eight percent (28%) of girls in West and Central Africa have had a live birth by the age of 18 while Eastern and Southern Africa has 25%. A study done in Uganda by Nabugoomu et al in 2020 found that more than one out of four adolescents (15–19) years) become pregnant with the rates being higher (27%) in rural than urban Uganda (19%) (Nabugoomu et al., 2020).

A study conducted among patients in a semi-urban tertiary hospital in India showed that in a total of 300 women who were interviewed on knowledge about the prevention of unwanted pregnancy almost 96% of them had heard about the prevention of unwanted pregnancy and only 42% were actually practicing unwanted pregnancy prevention, (Agarwal et al., 2017).

According to research done by John Bosco Mutuku in Kenya in 2019, poverty was a major factor as the level of income of parents is a factor, and girls from poor households were likely to be influenced into teenage pregnancy. The combined mean was 4.34 =STDV of 0.835 where the majority agreed poverty influence teenage pregnancy in Kenyan Public Primary Schools. Respondents rated the level of income to parent the highest rated statement with a mean of 4.65=STDV of 0.84. Cultural factors had a major effect on teenage pregnancies where forced marriage and gender roles were the most highly rated state-

ments of this objective. The two statements with means of 4.78 and 4.62 respectively which is why they have rated a very great extent of effect. (John Bosco M *et al.*, 2019)

The study done in the Kibuku district in Eastern Uganda revealed that the major cause of teenage pregnancy is the lack of guidance due to guardians and parents who are reluctant or do not understand the need to educate teenagers about vice and sexual reproductive behavior which leaves the teenagers not properly guided during their adolescent stage of development yet this is the critical stage in which their cognitive, emotional, psychological and social skills mature (Manzi F 2018).

The teenage pregnancy rate of 25% in Uganda is worrying though it may seem low compared to 28% in sub-Saharan countries and West and Central Africa. Young mothers in Uganda risk poor maternal and child health, being isolated attempting unsafe abortions, failure to continue with school, and poverty. This paper describes the perceptions and recommendations of young mothers, families, and community members on why the high rate of teenage pregnancies in Uganda and how these can be reduced (Nabugoomu *et al.*, 2020)

However, there are no studies about teenage pregnancy that have ever been conducted in Kyotera district. Therefore, this study aimed at assessing factors influencing teenage pregnancy among adolescents attending the adolescents' clinic at Kalisizo general hospital, Kyotera district in Uganda.

## 2. Methodology

### 2.1. Study design.

The study was a descriptive cross-sectional one in which a quantitative method of data collection was used. The qualitative method establishes a clear orientation while the quantitative approach measured the respondents' knowledge, attitudes, and opinions.

### 2.2. Study area.

The study was carried out at Kalisizo General Hospital, in the Central Region of Uganda, lo-

cated in Kalisizo town, in Kyotera District, on the Masaka–Mutukula Road, about 30km southwest of Masaka Regional Referral Hospital. The study was carried out from December 2022 to January 2023

### 2.3. Study population.

This study was conducted among female adolescents (15-19 years) attending adolescents' clinic at kalisizo general hospital in kyotera district.

### 2.4. Sample size determination.

The sample size was determined using Fishers *et al.*, 2003 formula.

$$N = z^2 p (1-p)$$

D2

Where d = margin of error

N= minimum sample size

Z=standard normal deviation set at 95% confidential level corresponding to 1.96

P= existing prevalence.

Therefore, taking

$$P = 5.1\% = 0.051$$

$$Z = 1.96$$

$$1-p = (1-0.051)$$

$$D= 5\% = 0.05$$

$$\text{Thus, } n = (1.96)^2 \times 0.051 \times (1-0.051) \times (0.05)^2$$

Therefore, 75 participants

### 2.5. Sampling techniques

A simple random sampling technique was used to select the study population. This is because all teenagers between (13-19years) were eligible to participate in the study. Only pregnant teenagers who were selected and were willing to participate in the study were interviewed.

### 2.6. Sampling procedures

A simple random sampling technique was employed by selecting pregnant teenagers randomly since all are eligible to participate in the study.

### 2.7. Data collection method.

The researcher used questionnaires to collect data from female adolescents aged 13-19 years. This is because it enables the collection of data within a short period and at a relative cost.

## **2.8. Data collection tools.**

A self-administered questionnaire was used for the literate females and those who didn't know how to read or write were helped by the researcher to interpret the questionnaire.

## **2.9. Data collection procedure**

Questioners were administered to respondents who were asked to fill the gaps where necessary or to tick in the box with the appropriate answer (for yes or no). Those respondents who were unable to read and write will be helped to read and interpret questions and will be guided when answering questions by the researcher and with the help of a research assistant.

## **2.10. Piloting study.**

A pilot study was carried out a week before the start of actual data collection and it was done among a group of 10 adolescent females at an adolescents' clinic to whom the questionnaire was administered for pre-testing to check the efficiency of the questionnaires and to rectify any errors before actual data collection is started.

## **2.11. Inclusion and Exclusion Criteria**

### **2.11.1. Inclusion criteria**

All pregnant teenagers that were present on a particular day of the study were interviewed.

### **2.11.2. Exclusion criteria**

This study excluded teenagers who were not willing to participate, those in critical conditions, those not mentally sound, and those who were not pregnant.

## **2.12. Quality control.**

The quality of the study was guaranteed by taking into consideration the following. Pre-visits to the study area for the exercise with authorities to be conducted before the study.

Data collection was done by the researcher himself. Research instruments like questionnaires were checked for errors of omission to ensure consistency completeness and accuracy in filling out the questionnaires.

## **2.13. Data analysis and presentation.**

Data were recorded, categorized, cleaned, coded, and analyzed manually using a summarized data master sheet and reviewed for accuracy, consistency, and completeness.

Later data was analyzed using Microsoft Excel, results will be presented using graphs, pie charts, and tables

## **2.14. Ethical considerations.**

The proposal was presented to the school research committee for approval before beginning the study. Permission got from the CHAIRMAN students committee for Kalisizo General Hospital for carrying out the study. Confidentiality, dignity, and respect of all participants were observed throughout the study as participants' data were kept confidential.

Participants were assured that there will not be any form of harm if they don't wish to participate in the study. Proper consent in writing was also obtained from the study participants before questionnaires were issued.

## **3. Results:**

Table 1 shows that the majority 57(76%) of the respondents were between 17-19 years old and the rest 18(24%) of the respondents were between 13-16 years

From the table above, most 42(56%) of the adolescents were single, 31(41.33%) were married and 2(2.67%) were neither married nor single as some lost their husbands though they were staying in the houses they had built for them with their children.

About religion most 31(41.33%) of the respondents were catholic, 22(29.33%) were Muslims, 11(14.67%) were protestants, 8(10.67%) were seventh day Adventists and others accounted for 3(4%) of the total number of the respondents.

According to tribe majority 49(65.33%) of the respondents were Baganda, 13(17.33%) were Banyankore, 4(5.33%) were Basoga, 3(4%) were Bakiga and others accounted for 6(8%) of the total number of all the respondents.

Table 1: Distribution of respondents by social demographic characteristics (n=75)

Variable		Frequency(n=75)	Percentage (%)
Age	13-16	18	24
	17-19	57	76
Total		75	100
Marital status	Single	42	56
	Married	31	41.33
	Others	2	2.67
Total		75	100
Religion	Catholic	31	41.33
	Muslims	22	29.33
	Protestants	11	14.67
	Seventh day Adventist	8	10.67
Total	Others	3	4
		75	100
Tribe	Baganda	49	65.33
	Munyankole	13	17.33
	Musoga	4	5.33
	Mukiga	3	4
	Others	6	8
	Total		75
Total Nationality	Ugandan	74	98.67
	Kenyan	0	0
	Tanzanian	1	1.33
	Rwandese	0	0
	Others	0	0
Total		75	100
Occupation	Farmer	38	50.67
	Business Woman	9	12
	Student	2	2.67
	House wife	22	29.33
	Others	4	5.33
	Total		75
Education level	Primary	39	52
	Secondary	25	33.33
	Certiftcate	4	5.33
Total	None	6	8
	Others	1	1.33
		75	100

About Nationality, almost all 74(98.67) of the respondents were Ugandans, and only 1(1.33%) were Tanzanians. None of the respondents was from, Kenya, Rwanda, or any other country.

Again, the table above results show that the highest number 38(50.67) of respondents were Farmers, 9(12%) business women, 2(2.67%) were students, 22(29.33%) were housewives and 4(5.33%) were involved in other activities.

About education level, majority 39(52%) of the respondents stopped at primary level, 25(33.33%) secondary level, 2(5.33%) certificate level and 6(8%) did not attend any institution of learning 1(1.33%) reported attending others.

### **3.1. Social-Economic Factors Influencing Teenage Pregnancy.**

According to the respondents in Figure 1, low use of contraceptives was the 69(92%) cause of teenage pregnancy only 6(8%) reported that low contraceptive use does not increase teenage pregnancy.

From Table 2 above majority 50(66.67%) reported that limited access to contraceptives was the main reason for low use of contraceptives, 9(12%) reported that lack of knowledge about their use, and only 16(21.33%) reported that both reasons for low contraceptive use.

In Figure 2, Out of 75 respondents 57(76%) reported that being out of school influenced teenage pregnancy and 18(24%) reported that being out of school does not influence teenage pregnancy.

In Figure 3, Out of the 57(76%) respondents who reported that being out of school influenced teenage pregnancy, the majority 35(61.4%) said that because being in school creates behavioral change, 11(19.29%) because, School attendance provided structure and supervision which may decrease the chances to be exposed to sexual practices, 10(17.54%) reported both, and only 1(1.75%) reported none of the above.

From Figure 4 the highest number 58(77.33%) reported that being poor influenced teenage pregnancy and 17(22.67%) reported that being poor has no effect on teenage pregnancy.

From Table 5 above majority 27(46.55%) reported that poverty-related vulnerabilities, in-

creased conditions for lack of education, and teenage pregnancy, 22(37.93%) reported that Poverty could drive adolescents to commit to early marriage and school dropout and 11(18.96%) reported both none of them said none.

From Table 7 above 55(73.33%) respondents revealed that being in a rural area increased the risk for teenage pregnancy, 20(26.67%) reported urban areas. 46(61.33%) reported that because Girls from rural areas were least likely to have access to quality education as well as sound sexual reproductive health services, Girls from urban areas were likely to have access to quality education as well as sound sexual reproductive health services were 23(30.67%), None of the above 0 and 6(8%) specified others.

### **3.2. Knowledge Of The Respondent Towards Control Of Teenage Pregnancy.**

In Figure 5, Out of 75 respondents, Only 63(84%) had knowledge about control of teenage pregnancy using different contraceptive methods but the rest 12(16%) had no knowledge about control of these unwanted pregnancies.

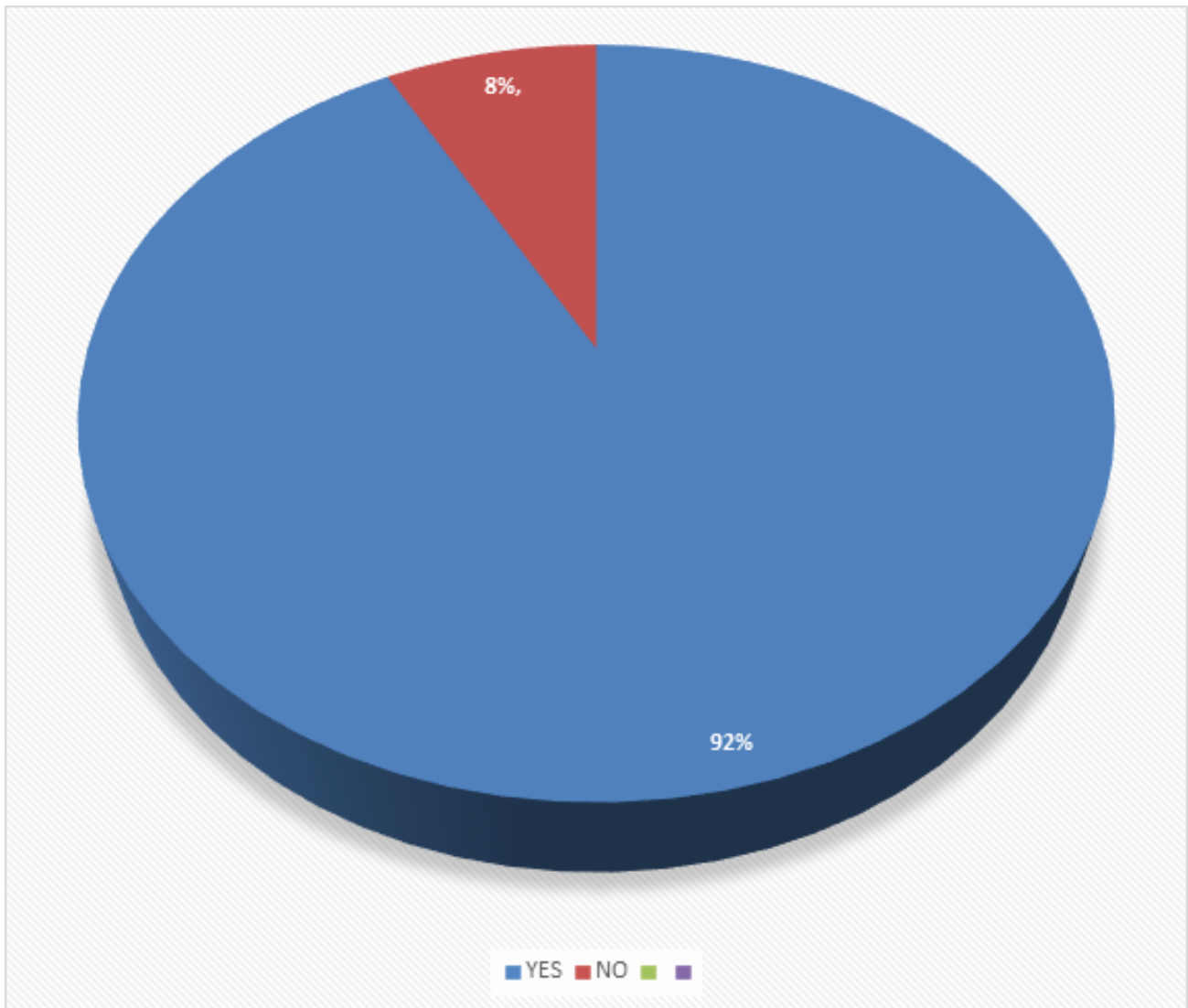
Figure 6, Out of the 63(84%) who knew about control of teenage pregnancy, 41 (65%) knew condoms, IUDs were 2(3.17%), pills were 7(11.11%), Implants were 5(7.94%), 6(9.52%) knew injectable methods and 2(3.17%) knew all the above methods of control of teenage pregnancy.

Figure 7 shows that out of 75 respondents, 58 (77.33%) had ever used emergency contraceptives and only 17(22.67%) had never used contraceptives.

In Figure 8, all the respondents 75(100%) reported that they had ever heard about sex education though from different sources as seen below. In figure 9, out of 75 respondents, 9(12%) reported sex education from their mothers, 2(2.67%) from newspapers, 28(37.33%) from classroom discussions, 32(42.67%) from health workers and 4(5.33%) reported other sources like friends.

### **4. Health impacts of teenage pregnancy.**

In Figure 10, Respondents showed different health impacts where most reported caesarian sec-



**Figure 1: Shows distribution of respondents according weather low contraceptive use increases the chances of teenage pregnancy of not (n=75)**

**Table 2: Distribution according to how low contraceptive use increases chances of teenage pregnancy. (n=75)**

REASON	NUMBER OF RESPONDENTS	FREQUENCY (%)
Limited access to contraceptives	50	66.67
Lack of knowledge about their use	9	12
Both	16	21.33

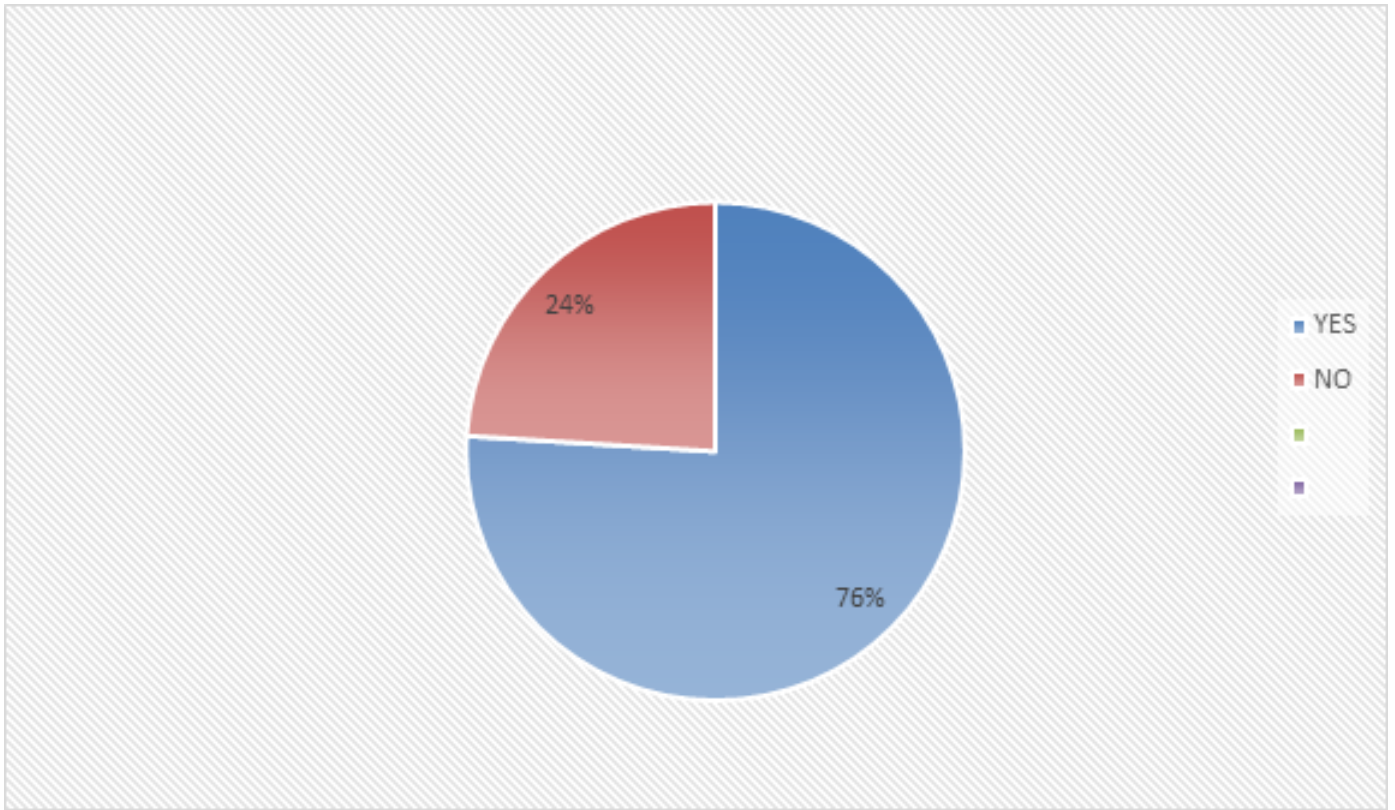


Figure 2: Distribution of respondents according to whether being out of school influences teenage pregnancy. (n=75)

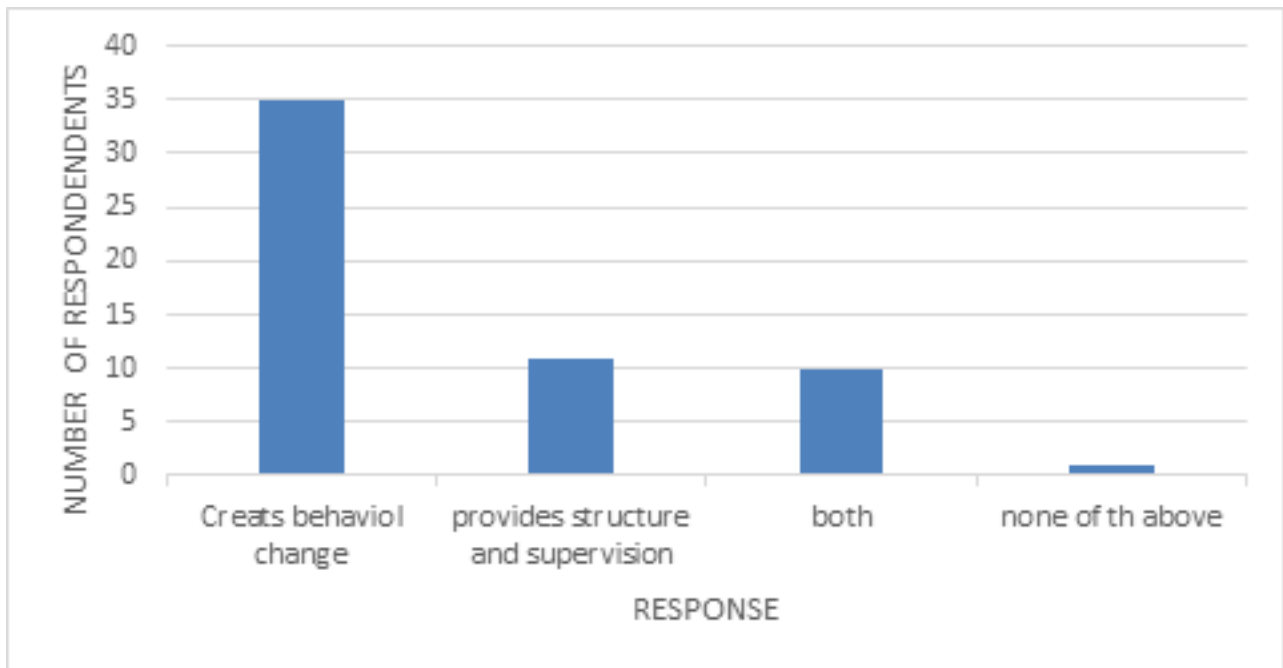


Figure 3: A graph showing distribution of respondents according to reasons why being out of school influences teenage pregnancy (n=57).



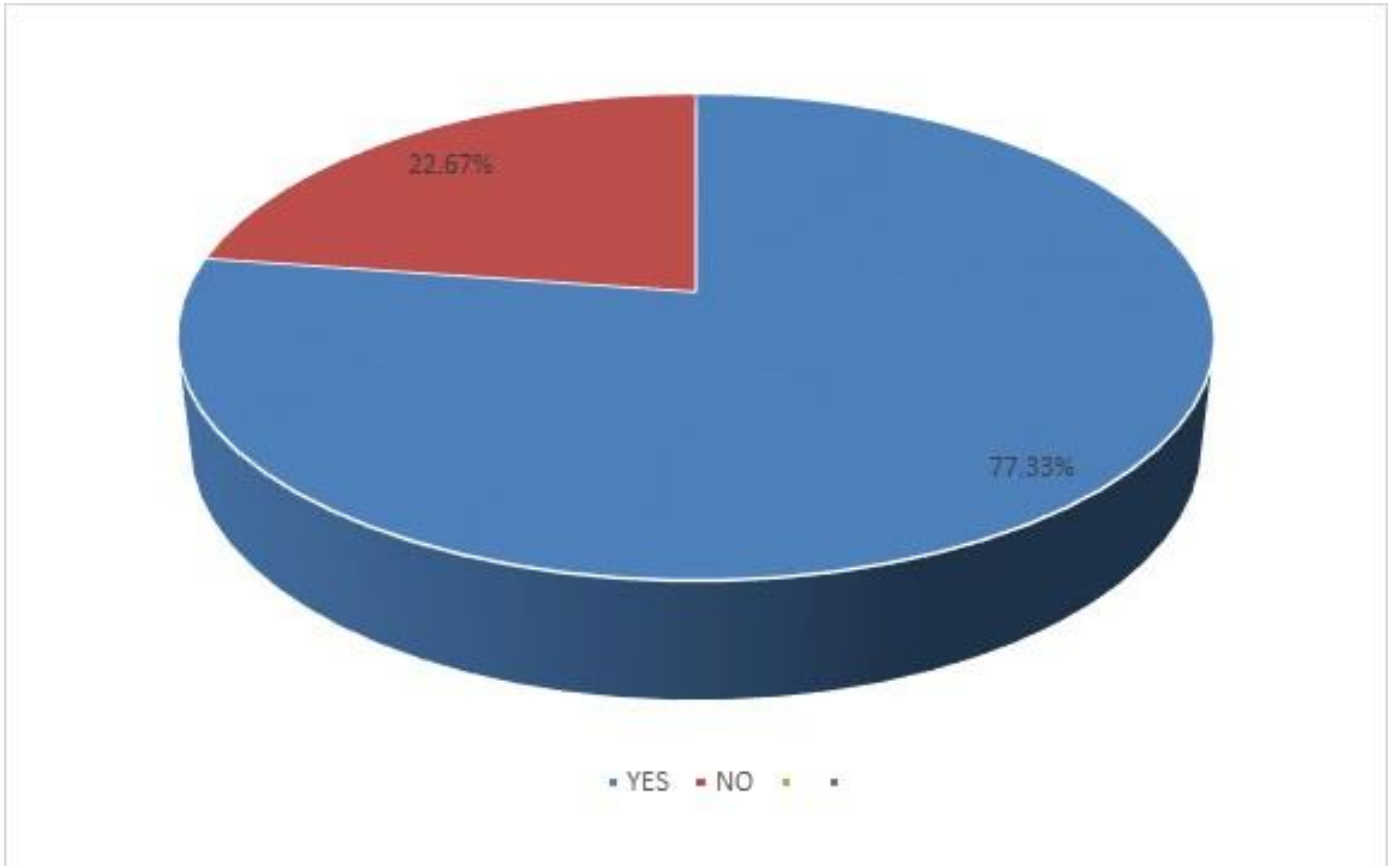


Figure 4: showing distribution of respondents according to weather poverty influences teenage pregnancy. (n=75)

Table 3: Showing distribution of respondents according to reasons why poverty influences teenage pregnancy.

REASON	NUMBER OF RESPONDENTS	FREQUENCY (%)
poverty related vulnerabilities, can increase condition for lack of education and teenage pregnancy.	27	46.55
Poverty can drive adolescents to commit to early marriage and school drop out.	22	37.93
Both	11	18.96
None of the above	0	0

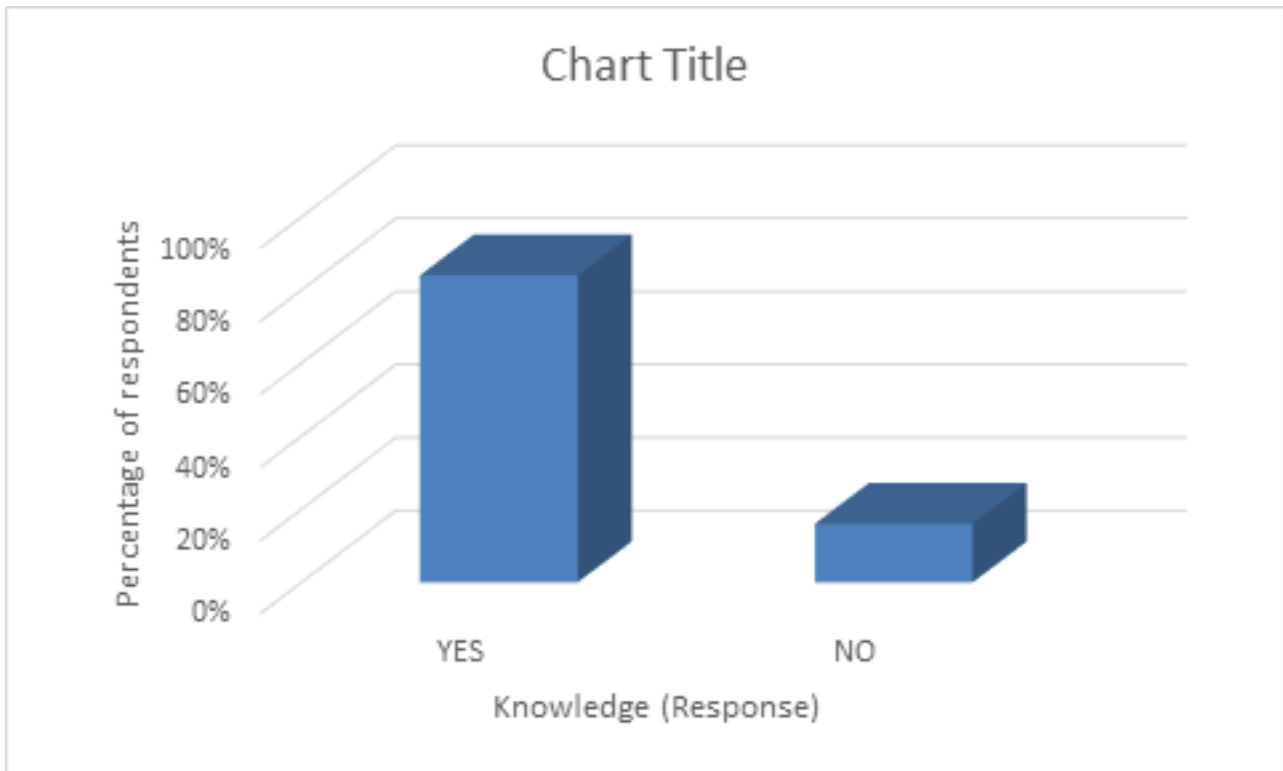


Figure 5: **Distribution according to knowledge about control of teenage pregnancy (n=75)**

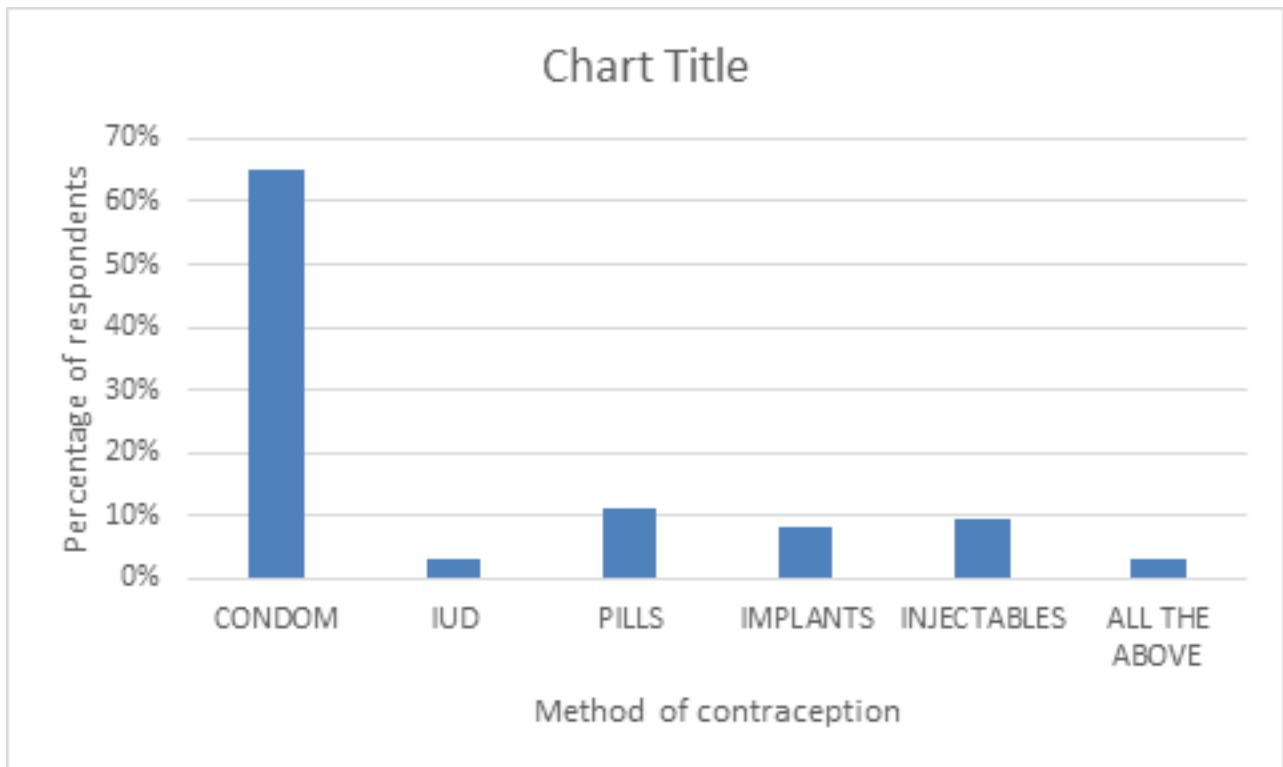


Figure 6: **Contraceptive methods in prevention of teenage pregnancy (n=63)**

Table 4: Showing distribution of respondents according to how location influences teenage pregnancy and why.(N=75)

Op- tion of reson- dents	Number	Freq uency(%)	reason	Number of respon- dents	Fre- quency(%)
ru- ral	55	73.33%	. Girls from rural areas are least likely to have access to quality education as well as sound sexual reproductive health services	46	61.33
ur- ban	20	26.67%	Girls from urban areas are likely to have access to quality education as well as sound sexual reproductive health services	23	30.67
			None of the above	0	0
			Others specify	6	8

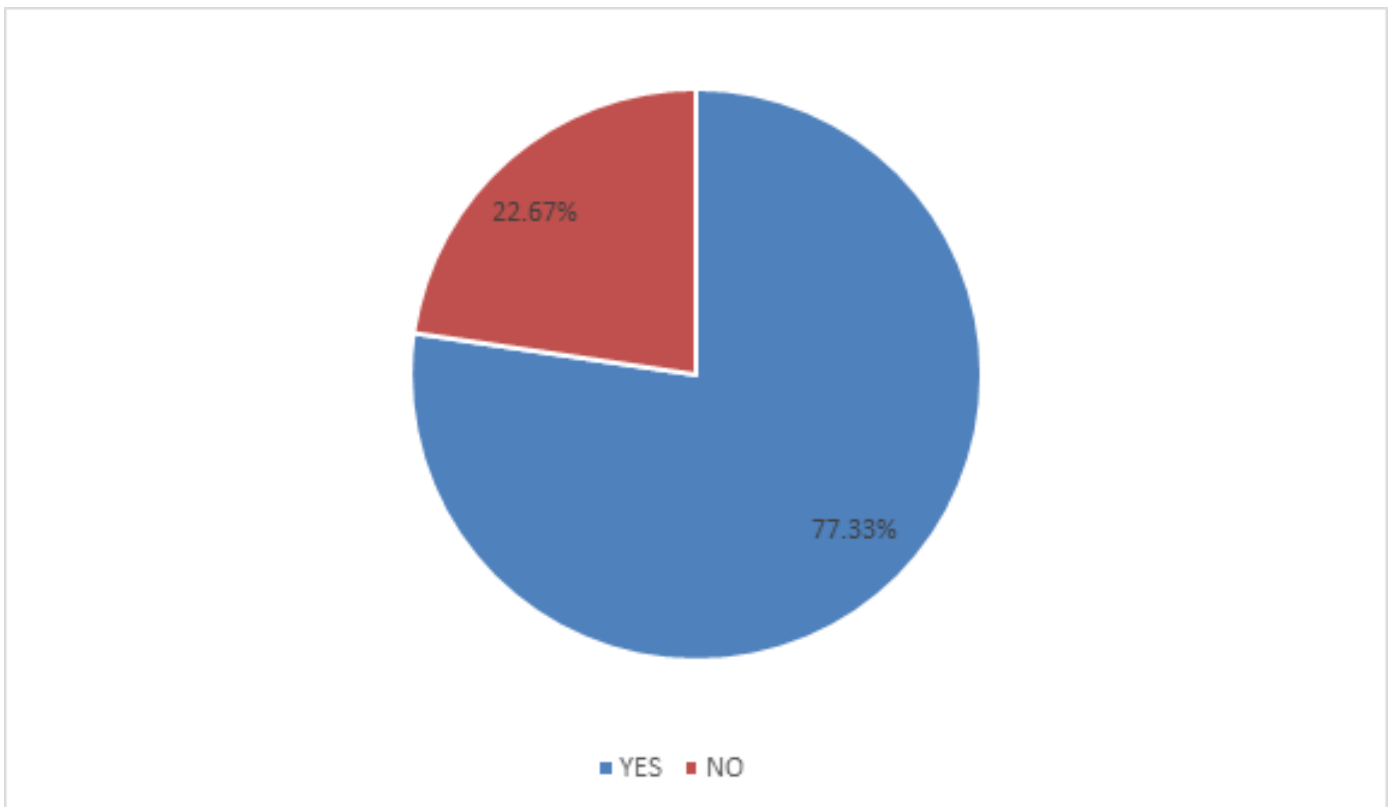


Figure 7: Distribution according to emergency contraceptive use(n=75)

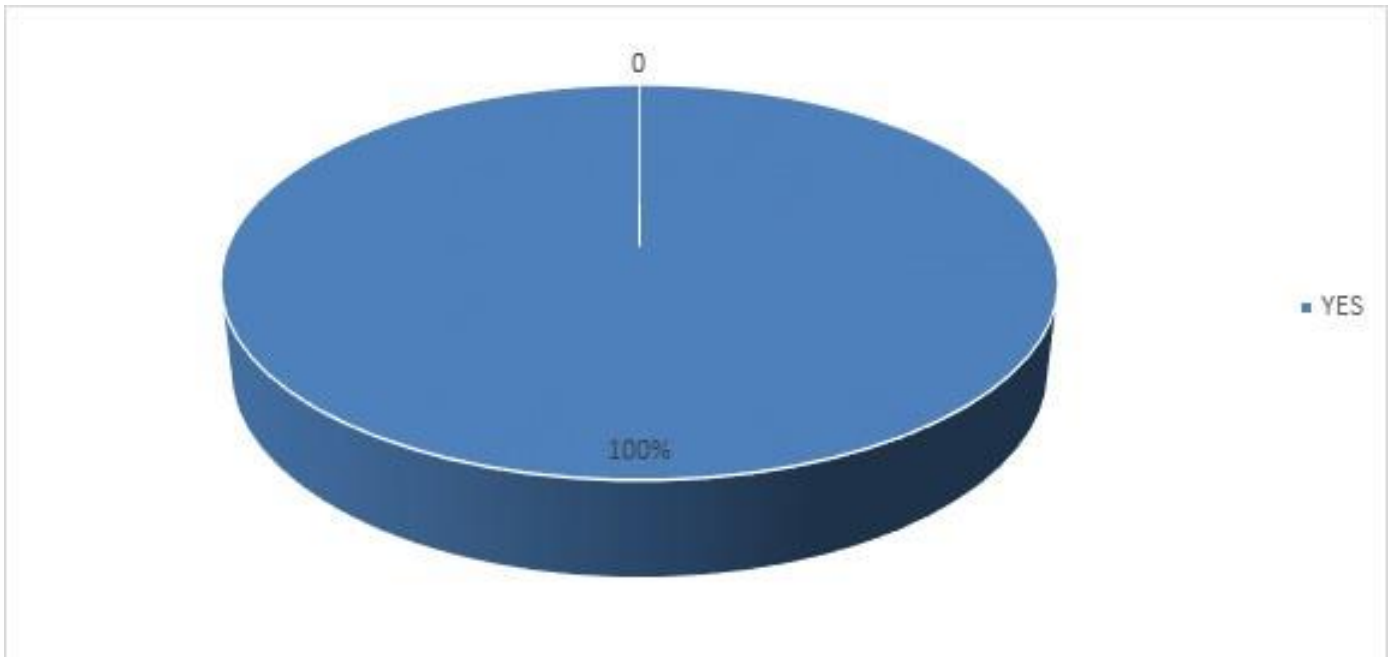


Figure 8: Distribution of respondents according to knowledge about sex education.

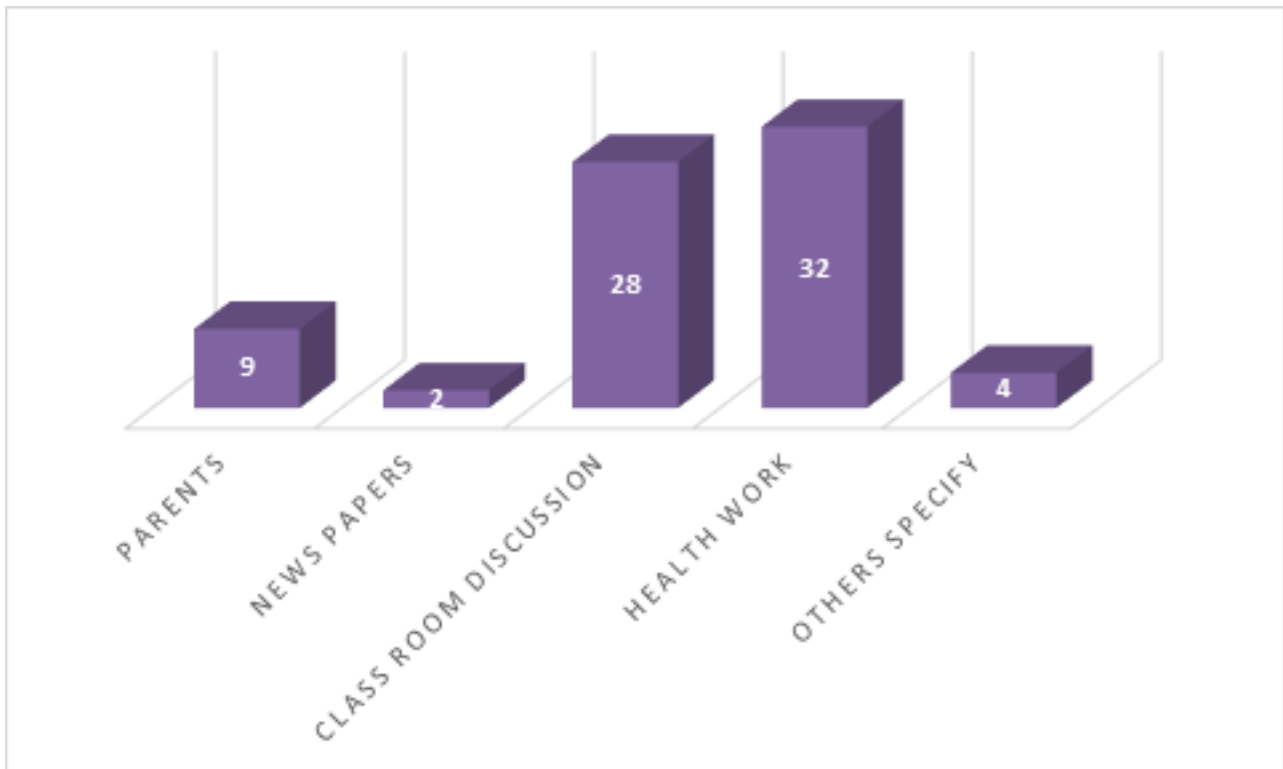


Figure 9: Distribution according to source of sex education(n=75)

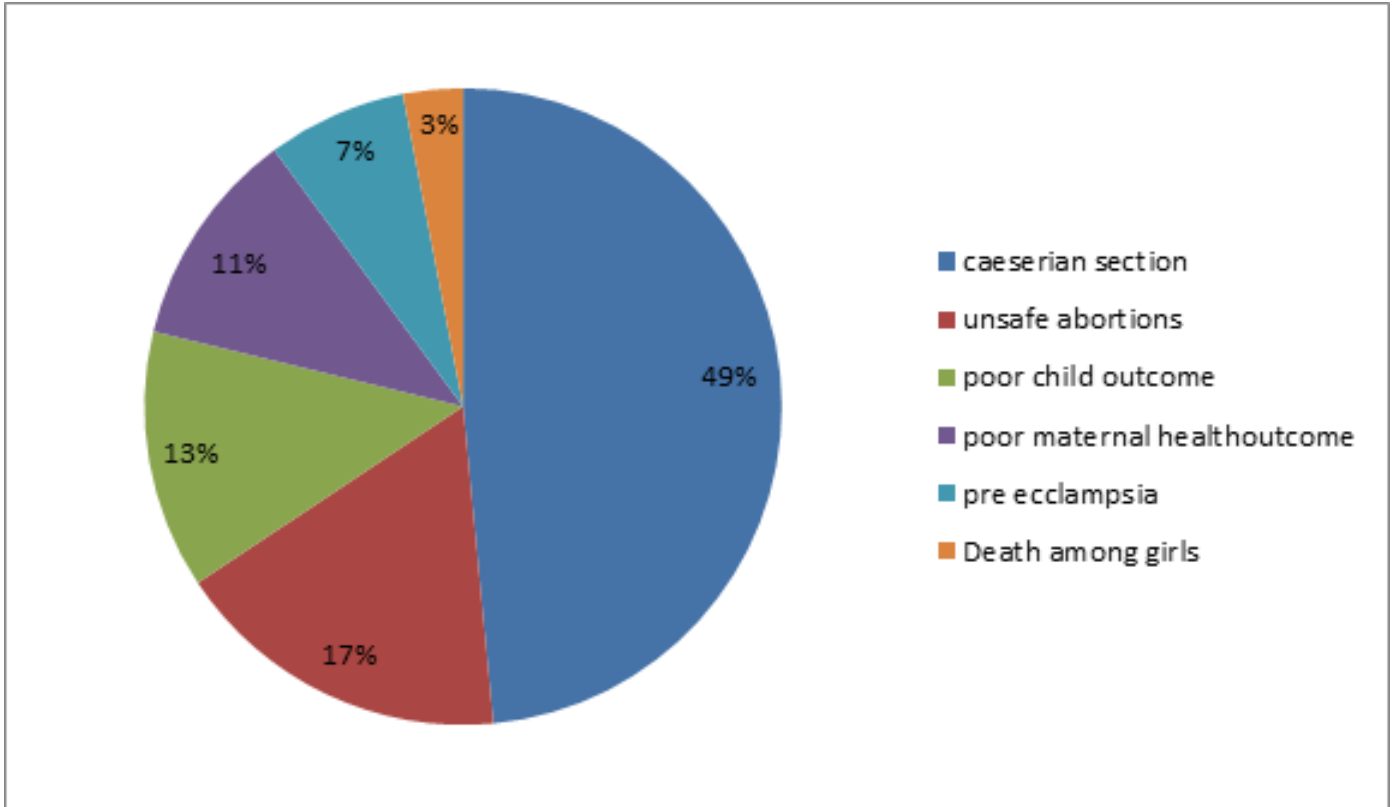


Figure 10: Distribution according to major effect of teenage pregnancy(n=75)

tion at 48%, dying during pregnancy at 17%, poor child health outcomes at 13%, poor maternal health outcomes at 11%, eclampsia, Death among girls at 3% and puerperal endometritis with 1%.

Out of 75 respondents almost all 68(90.67%) reported that teenage pregnancy affects one's academics only 7(9.33%) reported that one's education is not affected and one can continue with education during pregnancy and after giving birth.

In Figure 11, the majority of the respondents 72(96%) reported that one's mental health is affected by teenage pregnancy, and only 3(4%) reported that teenage pregnancy had no effect on one's mental health status.

In figure 12, majority of the respondents 70(93.33%) revealed that teenage pregnancy highly led to school dropouts and only 5(6.67%) reported that it had no effect of one's studies

## 5. Discussion.

### 5.1. Demographic data.

The demographic data of the respondents covered age, marital status, tribe, religion, Nationality, occupation, and level of education of the respondents.

According to age, the highest numbers of respondents (57) 76% were in the range of 17-19 years old because it is the most active reproductive age in females. The least number of respondents was (18) 24% and these were between 13-16 years because this age group obeys the commands of their parents and the parents are more protective and not so exposed as those between (17-19). The above findings were also because kalisizo general hospital in Kyotera district is in Uganda whose highest population is composed of the youth, these study findings are in line with the study conducted by Manzi and others in 2018 in Kibuku Eastern Uganda who in their study found out that teenage pregnancy is high in ages of 10 years to 19 years with a percentage of 36%

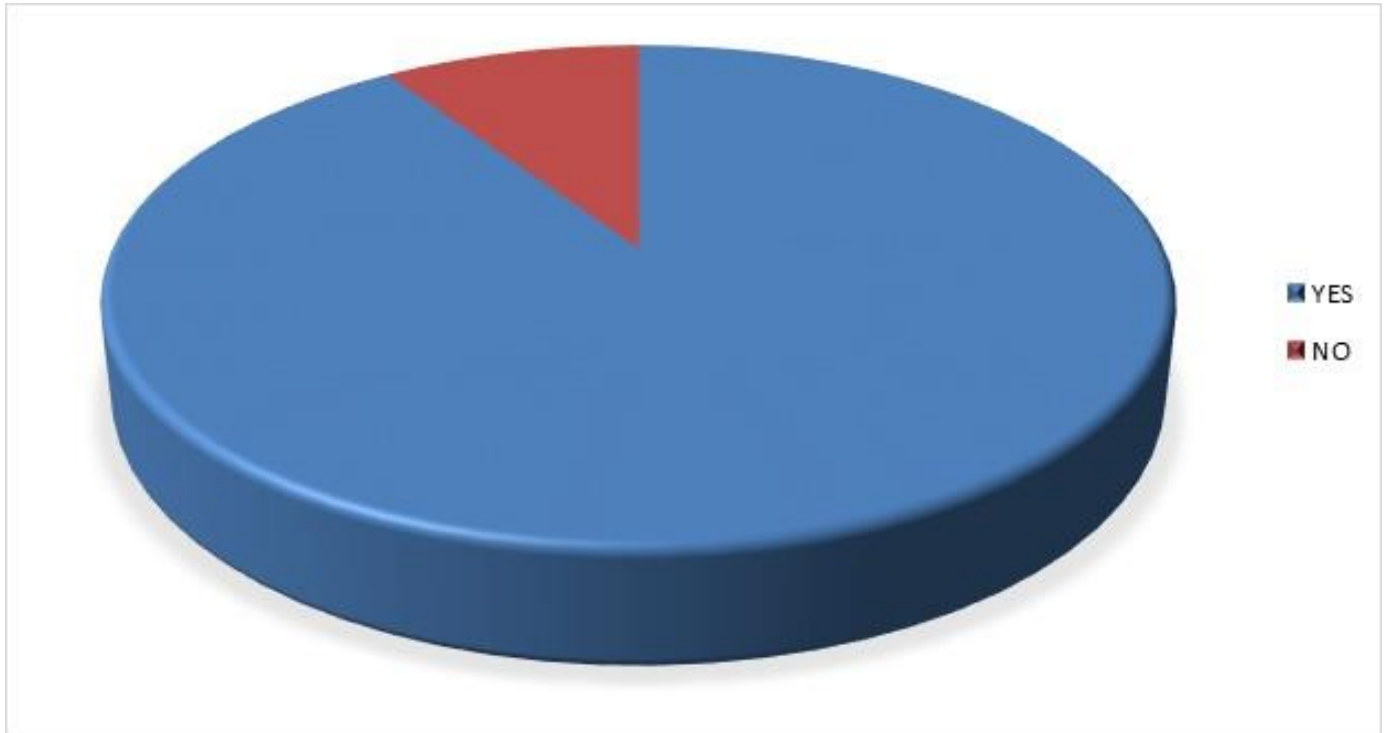


Figure 11: Distribution according to the effect of teenage pregnancy on academics (n=75)

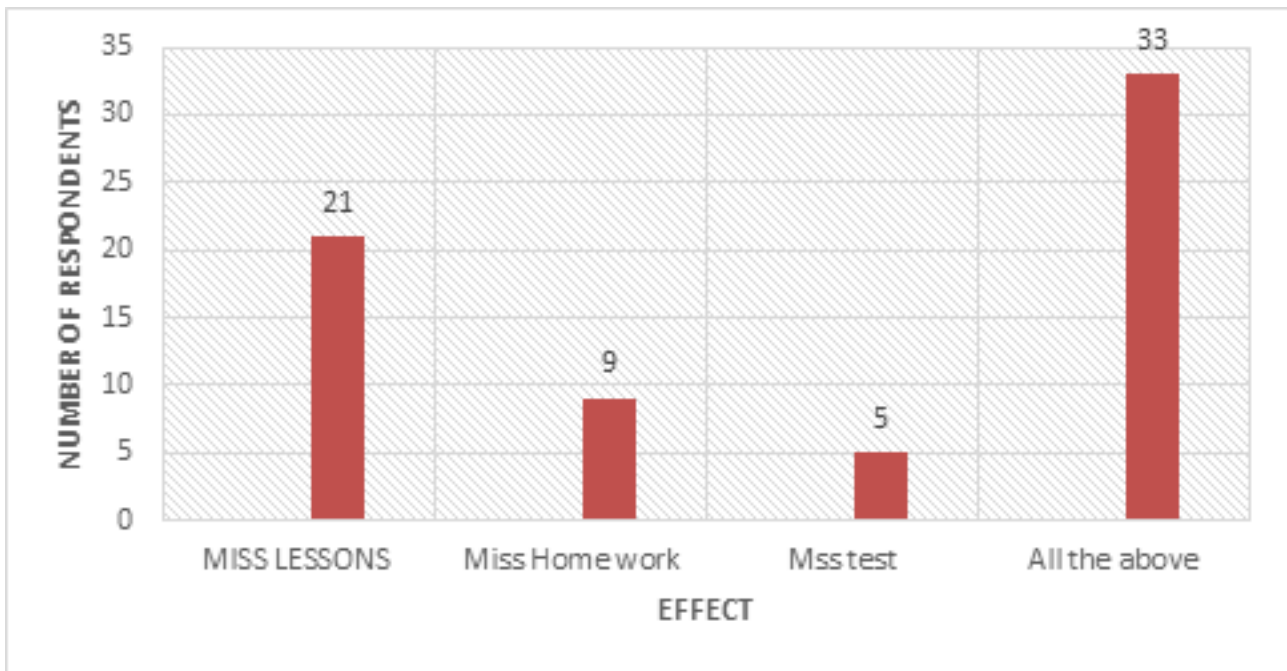


Figure 12: Shows respondents opinion about the relationship between teenagepregnancy and mental health.

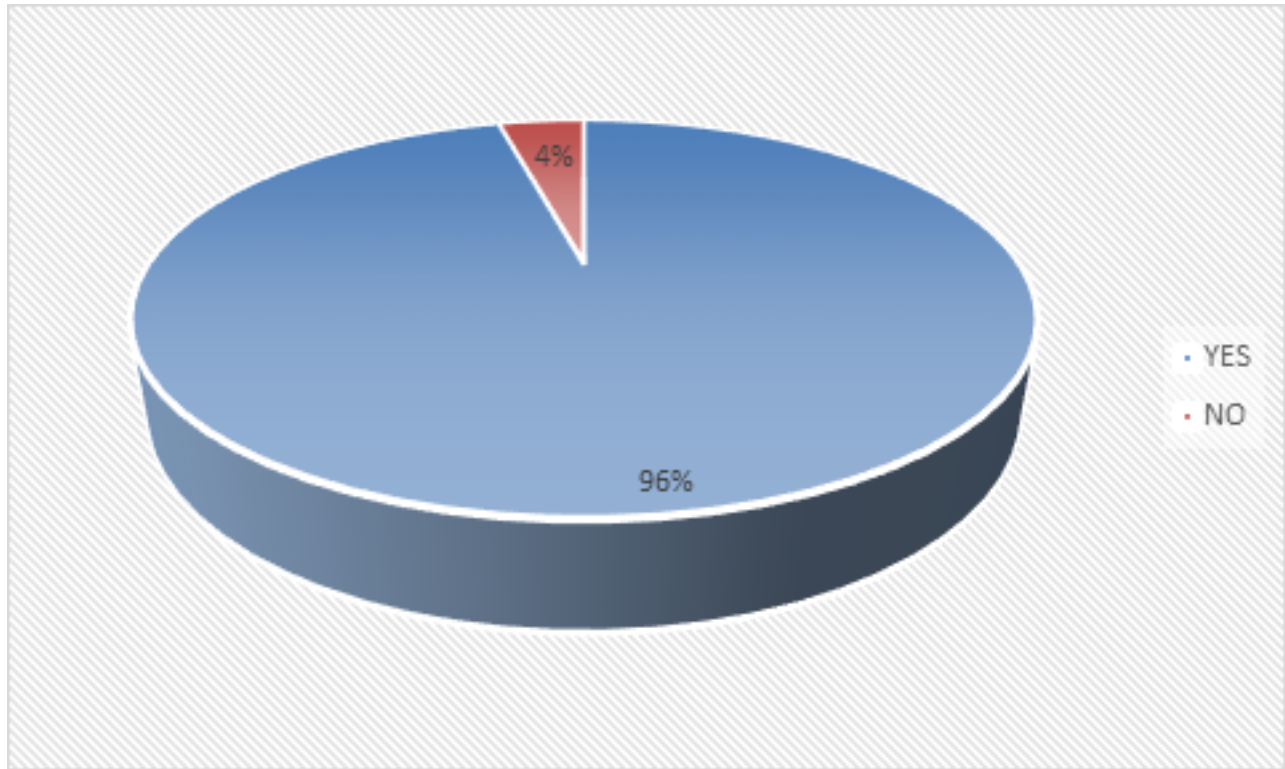


Figure 13: majority of the respondents 72(96%) reported that one's mental health is affected by teenage pregnancy and only 3(4%) reported that teenage pregnancy had no effect on one's mental health status.



Figure 14: Showing Distribution of respondents according to teenage pregnancy and school dropouts. (n=75)

because of the increased gender-based violence among the adolescents.

The biggest number of female adolescents 49(65.33%) were Baganda, this was because the study was done at Kalisizo general hospital which is in the Kyotera district that is found in the Buganda region and other tribes accounted for 34.66% because they are fewer dominant within the Buganda region, this study is not in agreement with that conducted by Ochen et al.,(2021)

in Lira

In their study, the highest number of respondents were Langi because the study was done in the Lira district whose highest population is composed of the Langi.

The majority of the respondents were Catholics (41.33%), because it's the most dominant religion in Kyotera District and other religions accounted for 58.67% because they are less dominant in this region. This study is not in line with that con-

ducted by Mezmur and others in 2021 in Malawi where the largest number of teenagers were belonging to Islam religion.

According to the education level of the female adolescents, the majority (52%) stopped at the Primary level this is because it is believed that when they stop at the primary level they have limited knowledge about control of teenage pregnancy, and they are not enlightened about the dangers that can arise from teenage pregnancy, followed by the secondary level because teenagers here believe that they are now mature enough to engage in sexual activities and also secondary schools have the highest numbers of teenagers compared to other levels of education Compared to other levels of education and the least (8%) is for those who never attended school, this is because these are less exposed to sexual activities, this justifies why there is an increasing number of teenage pregnancies in teenagers who stop at the primary level followed by secondary students. These study findings are in agreement with the study conducted by Habitu et al in 2018 in North Eastern Ethiopia and South Asia who in their study found that less educated girls have limited access to contraceptives hence contributing to 11% of teenage pregnancies and that conducted by Chiazor et al, 2017 in Nigeria.

### ***5.2. Social economic factors influencing teenage pregnancy among adolescents attending adolescents' clinic at kalisizo general hospital in Kyotera district in Uganda.***

The study revealed that the low use of contraceptives 69(92%) among respondents was the most cause of teenage pregnancy, this was because of the limited access to these contraceptives and the low knowledge about their use. This study's findings are in line with those of Nabugoomu and others in 2020 in Eastern Uganda who in their study found that lack of knowledge on how to control pregnancy, low acceptance/use of contraceptives, neglect by parents, sexual abuse, pressure to contribute to family welfare through early marriage or sexual transactions, lack of community responsibility, media influence, peer pres-

sure, cultural beliefs that promote early marriage/childbearing and lack of role models, 28% of adolescents gave birth in the sub-Saharan before 18 years of age.

The study results showed that 57(76%) of respondents acquire teenage pregnancy as a result of being out of school and this is because being in school creates behavior change and school attendance provides structure and supervision which may decrease the chances to be exposed to sexual practice and this agrees with the study done by Mezmur et al, 2021 which was done in South Africa and Malawi which also showed that being out of school is associated with teenage pregnancy

According to study findings being poor contributes 58(77.33%) to teenage pregnancy, this is because poverty can drive adolescents to commit to early marriages and school dropout, and poverty-related vulnerabilities can cause increased conditions for lack of education, this study is in line with that of study that of John Bosco M et al, 2019 in Kenya revealed that poverty was a major factor in the level of income of parent is a factor and girls from poor households were likely to be influenced into teenage pregnancy.

The study findings also revealed that girls from rural areas are 46.66% more likely to experience teenage pregnancies because staying in rural areas because Girls from rural areas are least likely to have access to quality education as well as sound sexual reproductive health services, this is in line with a study done by ChiaZor and others in 2017 in Nigeria were, girls from rural areas are 6% more likely to experience teenage pregnancy than those in urban areas, Girls from least developed communities and rural are least likely to have access to quality education as well as sound sexual reproductive health services that provide adequate information on birth control.

In conclusion, the use of contraceptives is the most social economic factor influencing teenage pregnancy among adolescents (92%), followed by being poor (77.33%), followed by being out of school (76%) and then staying in rural areas (73.33%).



### **5.3. Knowledge of adolescents about the control of teenage pregnancy.**

The majority of the respondents (84%) had good knowledge about the prevention of teenage pregnancy and this is respondents went to school and got some good knowledge about contraceptive use. health sex education session and some good information from different sources 45.33% of respondents reported that they got information about contraceptives from friends, 29.33% from Parents, 17.33% from television, only 2.67% from Newspapers and only 4% reported getting their information from other sources other than the ones listed in the questionnaire, and the minority of the respondents (16%) had no knowledge about prevention of teenage pregnancy and this is due to some did not go to school at all, lack sources of information about control of teenage pregnancy and limited utilization of sex education programs. These study results are in line with study findings of Agwal and others in 2017 in India who in their study about the prevention of unwanted pregnancy among patients in semi-urban tertiary hospitals in India results showed that most of their respondents (96%) had good knowledge about prevention of teenage pregnancy through their school attendance and sensitization

Out of 63 respondents who knew about contraceptives, 41 (65%) knew condoms, pills were 7 (11.11%), 6 (9.5%) knew injectable, Implants were 5 (7.94%), IUDs were 2 (3.17%), methods and 2 (3.17%) knew all the above methods of control of teenage pregnancy, the results are in agreement with those of Habib et al., 2017 in Pakistan about prevalence and determinants of unintended pregnancies amongst women attending antenatal clinics in Pakistan indicated that use of contraception was low and the commonly used being condoms (19%) followed by injectable (9.7%), the pills (9.6%), intrauterine devices (2.9%), and implants (2.5%) while 13.8% and 46.1% women reported use of rhythm and withdrawal method respectively.

Out of the 75 respondents, 58 (77.33%) had ever used emergency contraceptives, and only 17 (22.67%) had never used emergency contraceptives. These respondents got information about

these emergency contraceptives through sex education, health workers, and parents. and other sources like friends, therefore, have knowledge about teenage pregnancy prevention, this study's findings were not in line with the study done by Agwal and others in 2017 in India who in their study findings reported a very low (11.6%) awareness of emergency contraceptives which is because their study concentrated on all patients in a semi tertiary hospital in India while this study's focus was on female adolescents (teenagers) with whom it is thought to have heard about emergency contraceptives.

The majority of the respondents reported that they got information from Health workers 32 (42.67%), followed by 28 (37.33%) from classroom discussions, 9 (12%) respondents reported health education from Parents, 4 (5.33%) from other Sources then only 2 (2.67%) from newspapers. This is because they have easy access to health workers and many went to school hence, they can discuss sex education, some parents are not friendly to their children and few can access newspapers. This study is not in line with the study done by Hubert Nkabura 2020 in Mukono Parish Kanungu Uganda where the majority of respondents reported that 76% had prior knowledge about sex education whereas 24% had not. 42% got the information from the school as a gesture that respondents took part in the classroom discussion about sexuality, 28% from newspapers –straight talk, 16% from health workers, and 14% from their parents.

In conclusion, Most (84%) female adolescents had good knowledge about control of teenage pregnancy and all teenagers had knowledge about sex education.

### **5.4. Health impacts of teenage pregnancy.**

The study results showed that 36 (48%) of the teenagers in the study area were highly affected by caesarian section., to a high extent this was done as a medical intervention to save their life, this is not in line with the study done by Mezmur et al., In 2021 in Northern Kenya

whose results showed that adolescent women of less than 19 years at first pregnancy have an

80% higher risk for caesarian section for the first 6 weeks after birth since they find it difficult in giving delivery.

The majority 68(90.67%) of the respondents showed that teenage pregnancy led to poor academics of teenagers. this is so because teenagers miss lessons, miss homework, and also miss lessons.

The study results according to respondents revealed that 72(96%) reported that mental health was highly affected by teenage pregnancy because they lack social support from the family. Severe emotional and mental breakdown triggers the onset of evil behavior like suicide attempts or attempting to self-abort the baby. The teen mother experiences severe depression while facing negative feedback about the pregnancy from the society

The majority of respondents 70(93.33%) reported that teenage pregnancy led to school dropouts this study is in agreement with that of Manzi F and others, done in 2018 in Uganda and reported that the most striking effect of teenage pregnancy in Kibuku district was school dropout where 48% of the interviewed participants reported dropping out of school due to teenage pregnancy.

In conclusion, poor academics (90.67%) was the major health impact of teenage pregnancy.

## 6. Conclusion

Based on the findings of the study, low use of contraceptives is the most social economic factor influencing teenage pregnancy among adolescents (92%), followed by being poor (77.33%), followed by being out of school (76%%), and then stay- ing in rural areas (73.33.%). Most (84%) female adolescents had good knowledge about control of teenage pregnancy. all teenagers had knowl- edge about sex education though the majority got the information from health workers (42%) and 77.33% had good information about contracep- tive use and poor academics as the major health impact of teenage pregnancy.

## 7. Recommendations.

The researcher recommends that teenage- friendly services and teenage centers be instituted in Kalisizo General Hospital to health educate the teens on productive and reproductive health services, counseling services be put in place, and teaching the teens on the dangers of premarital sex.

The Government through the Ministry of Health should embark on massive sensitization campaigns on the dangers of teenage pregnancy using media bodies for example, by making educative adverts on local radios, televisions, magazines, and newspapers to improve aware- ness.

The Ministry of Education, Science, Technol- ogy, and Sports should include sex education in the curriculum of primary and secondary schools, strengthening programs such as PIASCY and Pa- triotism clubs towards educating the children on teenage pregnancy and its dangers.

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## 9. List Of Abbreviation

FP: Family planning.  
IUD : Ice  
MOH: Health STAVinistry of health  
STAV: Standard deviation  
UAHEB:Uganda allied health examinations board.  
UDHS :Uganda demographic health survey.  
UNFPA: United Nations fund programs associ- ation.

UNICEF: United Nations International Children

USA: States United States of America

WHO: World health organization

N.: Number

## 10. Source of funding;

None

## 11. Conflict of interest:

None

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