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# FACTORS CONTRIBUTING TO INCREASED CASES OF TEENAGE PREGNANCY AMONG TEENAGERS AT NAGURU TEENAGE INFORMATION AND HEALTH CENTRE, NAKAWA, BUGOLOBI-KAMPALA- A CROSS-SECTIONAL STUDY.

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## ABSTRACT

### Background

Globally, it has been estimated that approximately one million teenagers get pregnant each year. At the same time, about 24% of them become pregnant before the age of 19 in Uganda of which the Kiswa Community is among. The study's objective was to determine the factors contributing to increased cases of teenage pregnancies at Naguru Teenage Information and Health Centre.

### Methodology

Through a cross-sectional descriptive study design using a quantitative approach and through convenient sampling, a total of 62 teenage mothers were studied and data was collected using a semi-structured questionnaire.

### Results

Of 62 teenage pregnant mothers selected the majority 50(80%) of respondents were aged 16-19 years, only 5 below 15 years, with most having attained at least secondary education 43(69%) and only 2(3%) never went to school. Social factors like poverty 23(37%), early sexual contact 57(91%), increased crime rate 2(3%), and the majority 57 (92%) of the respondents did not use family planning before they conceived, health facility factors for example reluctance in family planning use 57(92%). However, alcohol influenced sexual behavior before the pregnancy with 79% being sober before engaging in sex.

### Conclusions

Of the 62 teenage mothers who participated in the study, the majority of the mothers were still in school by the time they got pregnant. Low education levels of teenage mothers, early sexual contact, alcohol influence, and low usage of family planning services use had a positive influence on teenage pregnancy among the respondents.

### Recommendations

As the researcher, I urge the government through the Ministry of Health to Increase the intensity of information sharing about teenage pregnancy among teenagers especially those living in rural areas/Villages

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## Background

The United Nations Children's Fund (2008), defines teenage pregnancy as “a teenage girl, usually within the age range between 13 and 19 becoming pregnant and denotes girls who have not attained the mandatory age of adulthood, which varies across the world.” There are enormous differences within regions in teenage births as well. For example, Nicaragua recorded the highest estimated teenage birth rates at 85.6 per 1000 teenage girls in 2021, compared to 24.1 per 1000 teenage girls in Chile Even within countries, there are enormous variations, for example in Zambia the percentage of teenage girls aged 15–19 who have begun childbearing (women who either have had a birth or are pregnant at the time of interview) ranged from 14.9% in Lusaka to 42.5% in the Southern Province in 2018. In the Philippines, this ranged from 3.5% in the Cordillera Administrative Region to 17.9% in the Davao Peninsula Region in 2017 (WHO, 2022)

Teen pregnancy is a global issue. It disproportionately affects young women around the globe on many levels and may limit future opportunities for teens. Globally, the teen birth rate is declining; however significant regional disparities persist (AZUMAH, 2019). Global adolescent fertility rates range from 1.2% in sub-Saharan Africa to 5% in Eastern Asia (WHO, 2011). Furthermore, the rates of teenage pregnancy also range from 30% in sub-Saharan countries in Africa to 2.9 % in South Korea with African

countries having the highest rate of teenage pregnancy (WHO, 2014).

Uganda has one of the highest rates of adolescent pregnancy in Sub-Saharan Africa. Teenage pregnancy and motherhood have remained a major health and social concern in Uganda because of their association with higher morbidity and mortality for both the mother and child. In addition to the physiological risks, there is a negative effect on the socioeconomic status of the mother, and hence the child, because current school policy is to have pregnant girls terminated from their education. 25% of Uganda's population is comprised of teenagers. It has been reported that a 25 % teen pregnancy rate among adolescents has been experienced in a population of 30 million people and therefore is a worrying issue for the government of Uganda (Gideon, 2013).

Teenage pregnancy has been identified as one of the primary causes of poverty because teenagers do not plan for themselves, let alone their children before giving birth and perhaps are not getting support from their communities. Approximately, 13 million children in the world are born to women under the age of 20, more than 90% in developing countries. Complications of pregnancy are the leading causes of mortality among women between the ages of 15 and 19 in such areas (Mayor, 2004). Other Health concerns associated with teenage pregnancy include obstructed labor, eclampsia, fistula, low birth weight, stillbirths, and neonatal death. The majority of teenage mothers are maltreated by the society. Most of them end up friendless and lonely. Teenage mothers feel they are unsupported in their attempt to cope with child rearing and coping with the vicissitudes of life (Amon, 2017).

Despite the Uganda government's efforts to address teenage pregnancy and its associated challenges, young girls continue to face the problem of teenage pregnancies which result in morbidities like Fistulae, anemia, abortions abandonment of babies, and other economic stressors. Teenage pregnancy accounts for 20-30% of maternal mortality in Uganda (Gideon, 2013) and accounts for the global burden of 10 % (WHO, 2016). Thus, the purpose of the study was to determine factors contributing to increased cases of teenage pregnancy among girls at Naguru Teenage Information and Health Center in the Nakawa division, Bugolobi-Kampala district.

## METHODOLOGY

### Study design and Rationale.

A cross-sectional descriptive study using the quantitative method was used to assess the factors contributing to high teenage pregnancies among teenagers at Naguru Teenage Information and Health Centre, across the sectional study and quantitative design is the numerical representation and manipulation of observations to describe and explain the phenomena that those observations reflect. It helps to quantify data and is easily presentable.

### Study area.

The study was conducted at Naguru Teenage Information and Health Centre located in Kiswa, Bugolobi-Nakawa division, Kampala district. District, located in the central region of Uganda with a population of approximately 365,200 in 2022

### Study population.

The study population consisted of all expectant or nursing mothers aged 10-20 years who attend ANC and MCH at Naguru Teenage Information and Health Centre

### Sample size determination.

Fisher's formula which was developed in 1995 was used to determine the sample size.

According to Fisher's formula, **n= z2pq/r2** Where; **n**=sample size in the population, z=standard deviation at the desired degree of accuracy: standard accuracy=95% which is =1.96, p=proportion of population of teenage mothers at Naguru Teenage Information and Health Centre is 40%, q=**1-p,** and **r**= magnitude of error the research is willing to accept is 10%.

Therefore **n= (1.96)2*(0.4) * (0.4) (0.1)2 n=62** teenage mothers

### Sampling procedure and Rationale.

A Convenient sampling method being one of the non-probability sampling methods was used since it involved drawing samples/selecting mothers who were easily accessible and willing to participate in the study. This method is cheap, easy, and time-saving (Krueger and Casey, 2009).

### Inclusion criteria.

The study included all teenage mothers aged 10-19 years who were not present at the time of data collection.

### Exclusion criteria.

Mothers in labor and very sick mothers.

### Definition of study variables

Study variables are things that have a quantity and quality that varies. And can either be independent variables or dependent variables (Karl and Wuensch, 2010).

### Independent Variables

factors contributing to increased cases of teenage pregnancies among teenagers at NTIHC like Demographic factors (age, tribe, location, level of education, and religion) were considered as the most distal determinants that affect the level of teenage pregnancies.

### Dependent Variable

The dependent variable was teenage pregnancies among teenagers at NTIHC

### Research instruments

Data was collected using semi-structured questionnaires administered to each respondent in privacy and simple language was used to explain some of the information not understood by the mothers. The questionnaire contained four sections: section.A (Biodata), section . B (Individual factors contributing to high teenage pregnancies), section. C (Social factors contributing to increased cases of teenage pregnancy), Section.D (Health facility factors contributing to increased cases of teenage pregnancy)

### Data collection procedure

The questionnaire was issued to each respondent, the steps were explained to the respondents one by one, and reasonable time was given to each respondent to read, understand, and respond. For those who didn't know English or the local language, an interpreter was used. The completed questionnaires were collected by the researcher himself.

### Data management

Data was managed to maintain the maximum level of confidentiality of information collected from each participant. Unauthorized personnel were not allowed to access the data except the researcher and research assistant who had the skill to manage the data to avoid any errors. Under safe conditions, data was collected during the time to ensure safety during the collection procedure.

### Data processing and analysis

Data was generated, processed, and analyzed using Word 2010, soft excel, and calculators and presented in descriptive forms of pie charts, tables percentages, graphs, and texts.

### Ethical considerations

A letter from the Kampala School of Health Sciences was received which introduced me to Naguru Teenage Information and Health Centre before I began the study and further permission was sought from Naguru Teenage Information and Health Centre. Participants were explained the study and only those who consented were included in the study confidentiality was ensured, and cultural beliefs and customs were respected.

## RESULTS

### Socio-Demographic Characteristics of Respondents.

Table 1: Shows the sociodemographic characteristics of the respondents. Results from the study indicate that the majority 50(80%) of respondents were aged 16-19years and the minority5 (9%)of the mothers being aged between 10-15years; religious denominations of mothers where the majority were Catholics and Moslems taking18( 29 %) each followed by protestants14( 23%) then Born-again being the minority with 12(20%) of the total teenage mothers; education levels of teenage mothers, with most mothers 43(69%) attaining secondary education, followed by primary level 16(26%), then those who didn't go to school and institution level being least with 2(3%) ; the occupation status of teenage mothers with highest being unemployed30(49%), followed by self-employed 18(29%), and employed mothers being the least making 14(23%) ; the tribes of mothers in the study population where, the majority14(23%) of the mothers were Baganda and Basoga, then the minority7( 11%) of the mothers were Bagisu and other tribes.

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**Table 1: A table showing the socio-demographic data of respondents (N=62)**

| PARAMETER | RESPONDENTS | PERCENTAGE |
|---|---|---|
| Age | | |
| 10-15 | 5 | 9% |
| 16-19 | 50 | 80% |
| 20 | 7 | 11% |
| SEX | | |
| Female | 62 | 100% |
| Male | 0 | 0% |
| RELIGION | | |
| Protestants | 14 | 23% |
| Catholics | 18 | 29% |
| Born again | 12 | 20% |
| Moslems | 18 | 29% |
| MARITAL STATUS | | |
| Single | 21 | 34% |
| Married | 41 | 66% |
| Divorced | 0 | 00% |
| HIGHEST LEVEL OF EDUCATION | | |
| Primary | 16 | 26% |
| Secondary | 43 | 69% |
| Tertiary Institution/University | 2 | 3% |
| No Education | 2 | 3% |
| OCCUPATION | | |
| Employed | 14 | 23% |
| Unemployed | 30 | 49% |
| Self-employed | 18 | 29% |
| TRIBES | | |
| Baganda | 14 | 23% |
| Banyankole | 9 | 14% |
| Basoga | 14 | 23% |
| Acholi | 11 | 17% |
| Bagisu | 7 | 11% |
| Others | 7 | 11% |

**Table 2: The table below shows the age of respondents by the time they started having sex.** (N=62)

| Age | No. of mothers | Percentage (%) |
|---|---|---|
| 10-15 | 5 | 9% |
| 16-19 | 57 | 91% |

## Individual factors contributing to teenage pregnancy

Findings in table 2 show that majority57 (91%) of the respondents started engaging into sexual intercourse by the age of 16-19 while minority5 (9%) started engaging into sexual intercourse by the age of 10-15years

From figure 1, findings indicate that the majority 60(97%) of the mothers were sober by the time they engaged into sexual intercourse while minority 2(3%) were not sober and were under influence of alcohol.

Table 3 shows respondent pregnancy status with highest being Unplanned 37(60%) of the respondents and planned pregnancies being the least, 25(40%) of the respondents.

Findings from figure 2 indicate that the majority 46(74%) of the respondents were single by the time they got pregnant and the minority 16(26%) of the respondents were already married.



**Figure 1: A pie chart showing whether mothers were sober by the time they engaged into sexual activities.** (N=62)

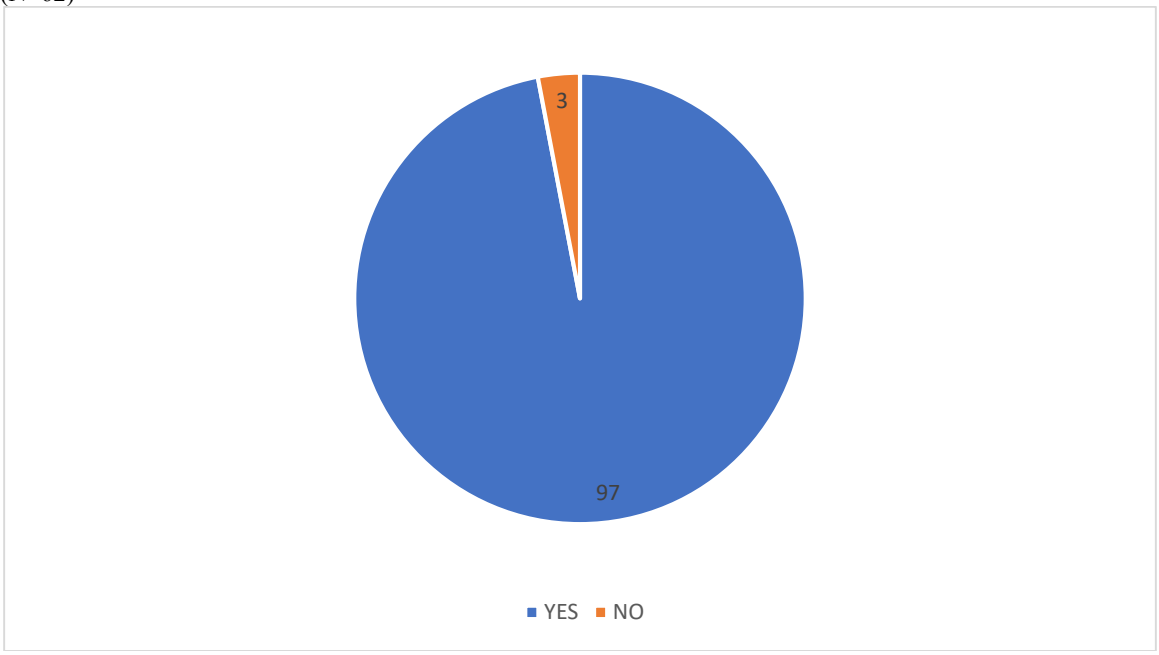


**Table 3: A table showing the pregnancy status of respondents.**

**(n=62)**

| Response | Frequency | Percentage |
|---|---|---|
| Planned | 25 | 40% |
| Unplanned | 37 | 60% |

**Figure 2: A graph showing Marital status of mothers before they conceived.**
(n=62)

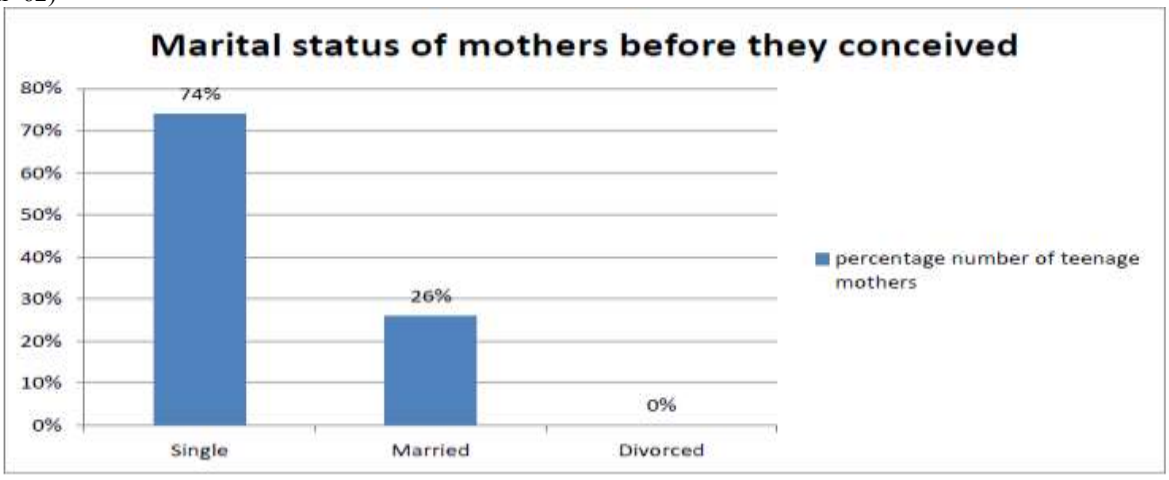

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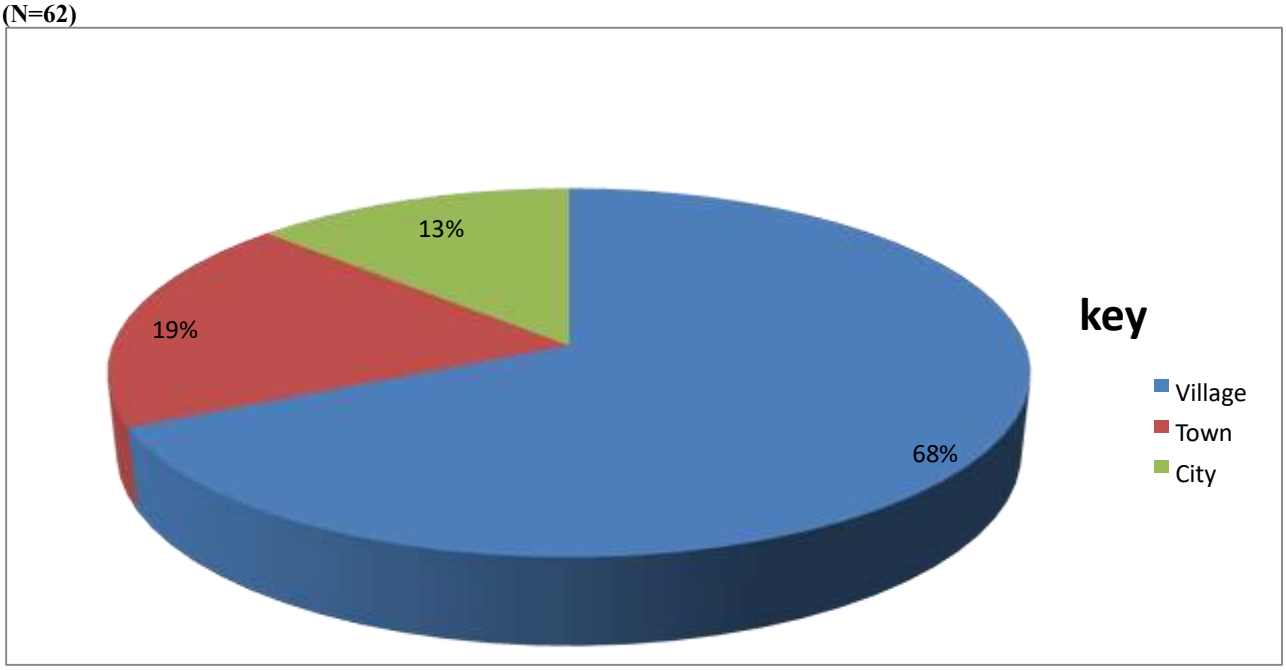
**Figure 3; A pie chart below showing distribution of respondents basing on the home locations of teenage mothers.**

**(N=62)**






## Social factors contributing to increased cases of teenage pregnancy.

Figure 3 shows the distribution of mothers basing on home location with majority42 (68%) of the respondents coming from villages and minority 8(13%) of the respondents coming from cities.

From the results in table 4, the majority 34(55%) of the mothers had one parent still living and minority8 (13%) of the mothers no single parent living.

Figure 4 indicates that there is a history of teenage pregnancy in families of most pregnant mothers 35 (57%) and no history in least of the pregnant teenage mothers, 27mothers (43%).

Results from figure 5 indicate that the majority 26(42%) of the respondents were in good relationship with their parents well as the minority 4(6%) of the mothers were in bad terms with their parents

Results from table 5 indicate that majority of the respondents 23(37%) got pregnant due to poverty well as minority of the respondents 2(3%) were affected by increased crime rate (rape and defilement).

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**Table 4; A table showing number of parents of respondents still living.**
(n=62)

| Parameter | No. of Respondents | Percentage |
|---|---|---|
| Both living | 20 | 32% |
| One living | 34 | 55% |
| None is alive | 8 | 13% |

**Figure 4: The pie chart below shows history of teenage pregnancy in families of teenage mothers.**
(n=62)

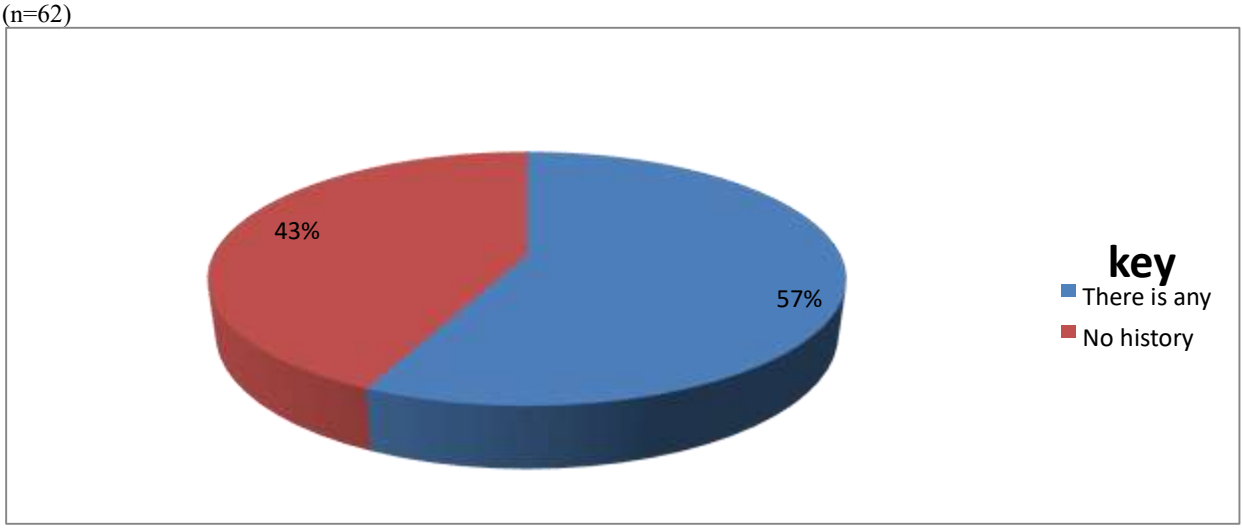


**Figure 5: The Bar graph below shows the relationship status of respondents with their parents by the time they hadn't yet conceived.**

(n=62)

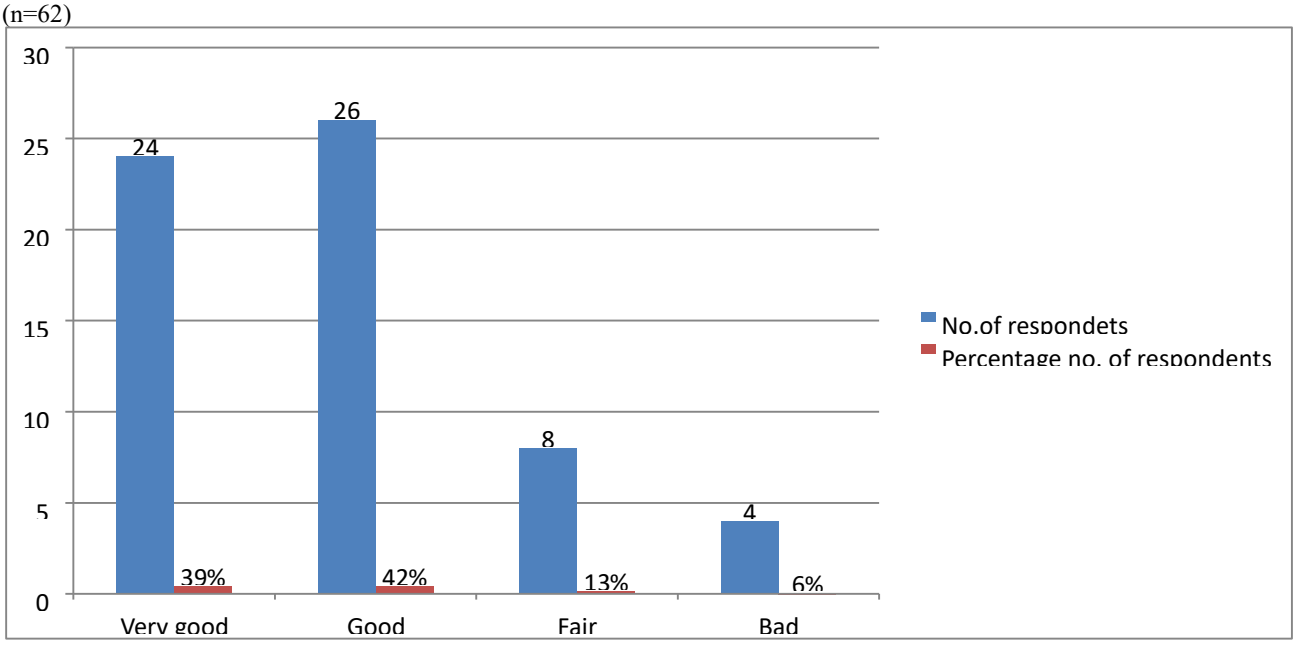

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**Table 5: The Table below indicates the circumstances that led to most cases of teenage pregnancy**.
(N=62)

| Response | Frequency (f) | Percentage (%) |
|---|---|---|
| Poverty | 23 | 37% |
| High growth spurts | 5 | 8% |
| Early marriage | 20 | 32% |
| Peer pressure | 8 | 13% |
| Lack of parental guidance | 4 | 7% |
| Rape and Defilement | 2 | 3% |
| TOTAL | 62 | 100% |

**Table 6: A table showing response to awareness of existence of sexual and reproductive health services in nearby health facilities to respondents**
(N=62)

| Response | No. of mothers | Percentage |
|---|---|---|
| Yes | 48 | 77% |
| No | 14 | 23% |

**Figure 6: A pie chart showing response of mothers on whether they accessed sexual and reproductive health services.**
(N=48)

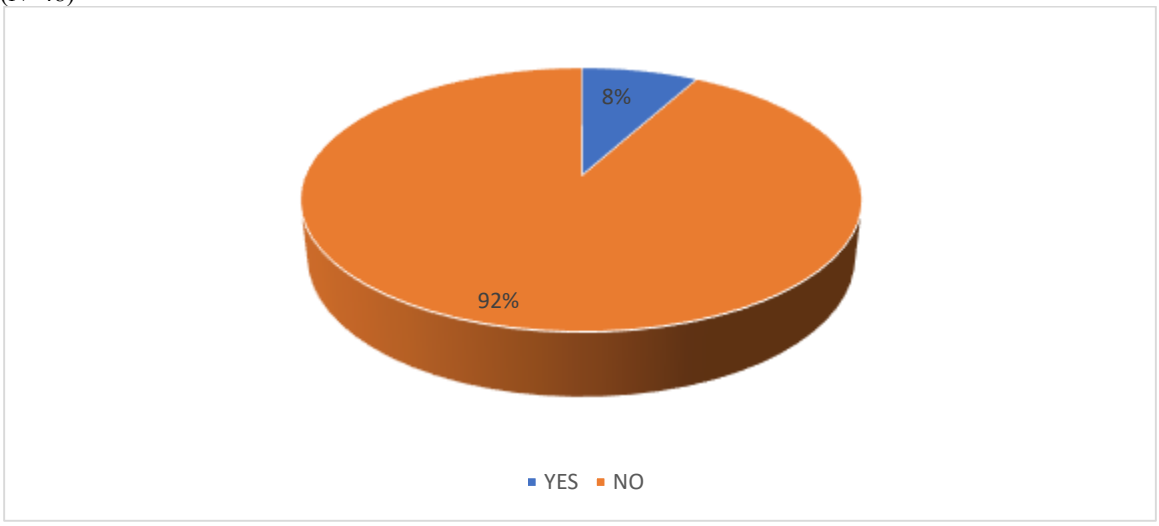
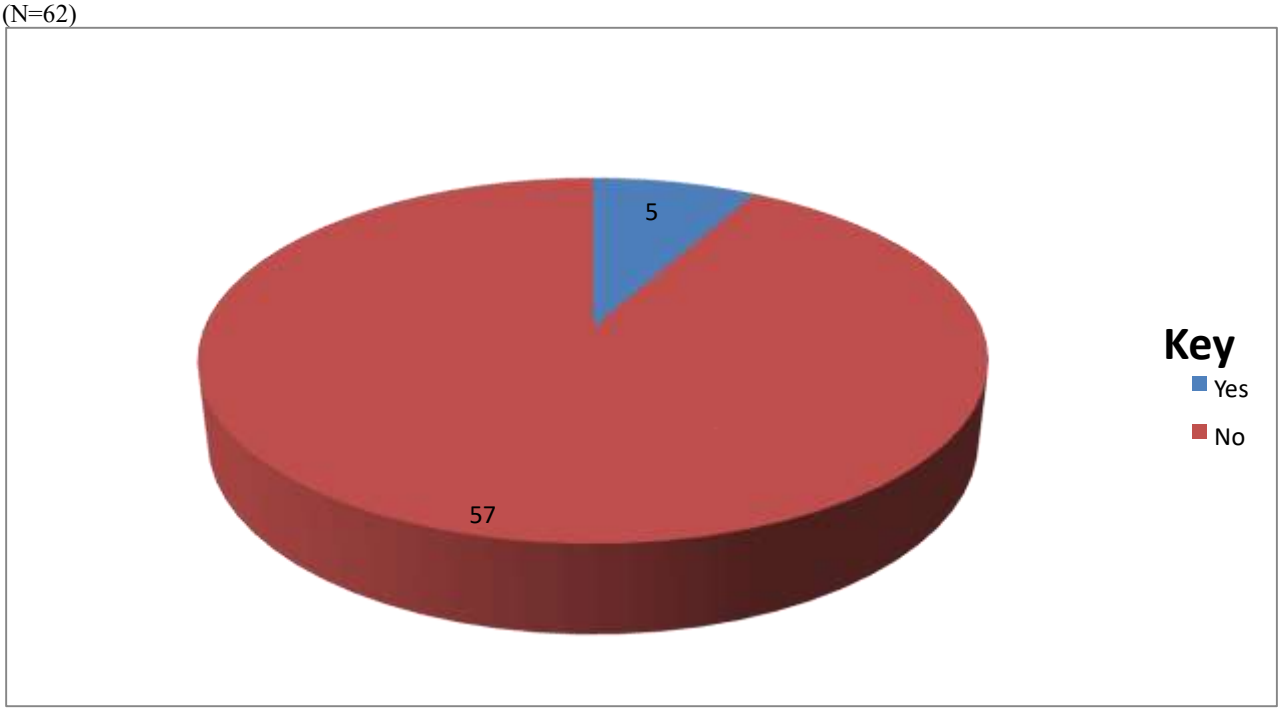


**Table 7: A table showing response of mothers on whether they've ever heard about any family planning method before there conception.**
(N=62)

| Response | Frequency | Percentage |
|---|---|---|
| Yes | 62 | 100% |
| No | 0 | 0% |

**Figure 7: A pie chart showing response of mothers on whether they were utilizing family planning before they conceived.**
(N=62)




## Health facility factors contributing to increased cases of teenage pregnancy.

From the results in table 6, majority 48(77%) of the respondents were aware of availability of sexual and reproductive health services at nearby health facilities well as minority14 (23%) were not aware of it.

From figure 6, results show that majority44 (92%) of the respondents did not access sexual and reproductive health services well as the minority4 (8%) of the respondents accessed the services.

Results from table 7 indicate that all respondents 62 (100%) knew about family planning.

From figure 7, results show that majority 57 (92%) of the respondents did not use family planning before they conceived well as the minority 5 (8%) used it and conceived.

Results presented on the graph above show that the majority2 (40%) of the respondents used pills and injection method wells the minority 0(0%) used withdraw method.

Results in table 8 show that the majority 23(40%) of the respondents didn't use any family planning method before getting pregnant due to myths associated with family

planning well as the minority 3(5%) didn't use any family planning method because they wanted to deliver babies.

Results in Table 9 indicate that the majority 2(40%) of the respondents conceived due to poor pill adherence and miss information about use well as the minority 1(20%) conceived when the implants were removed due to side effects



**Figure 8: A bar graph showing the family planning methods ever used by respondents.**

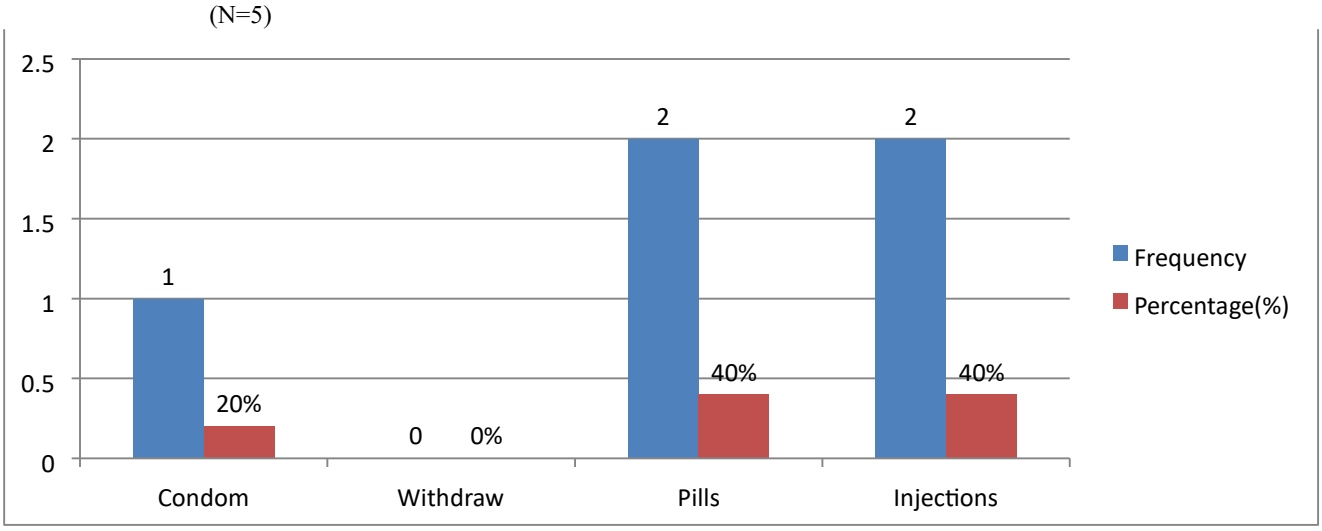



**Table 8: The table below shows reasons why most mothers didn't use any family planning method before they conceived.**
**(N=57)**

| Response | Frequency | Percentage |
|---|---|---|
| Myths associated with family planning | 23 | 40% |
| Fear of side effects associated with family planning | 22 | 39% |
| Religious factors | 4 | 7% |
| Wanted baby | 3 | 5% |
| Fear of unfriendly Health workers | 5 | 9% |

**Table 9: A table showing reasons why some respondents conceived amidst using family planning.**
(N=5)

| Reason | Frequency | Percentage |
|---|---|---|
| Removed due to side effects | 1 | 20% |
| Poor pill adherence | 2 | 40% |
| Miss information on the use | 2 | 40% |

## DISCUSSION

### Individual factors contributing to high teenage pregnancy at Naguru Teenage Information and Health Centre.

The study findings showed that the majority 57 ( 91%) of the respondents started engaging in sexual intercourse by the age of 16-19 while the minority 5( 9%) of the respondents started engaging in sexual intercourse by the age of 10-15years. These findings correlated to a study published by Stanford Medicine,2021 which found out that girls in the age range of 16-19 have fully developed secondary sex characteristics and so may want to explore and know how sex may feel like and hence may fall pregnant. As well another study done by Manzi et al. 2018, suggested that as teenagers grow up, their curiosity about knowing more about sex increases, and also the extent to which they feel sexual pressure increases hence engaging in sexual intercourse.

The study findings also indicated that the majority 60 (97%) of the mothers were sober by the time they engaged in sexual intercourse while the minority 2(3%) were not sober and were Under the influence of alcohol or any other drug. These findings contradict findings from the study done by Heil et al, 2011 which found that rates of unintended pregnancies were higher among substance-using teenagers especially Opioid users. Among treatment-seeking pregnant teenagers with opioid use disorders in the United States of America, 86% of pregnancies were reported to be unplanned hence increasing cases of teenage pregnancies.

The results from the study above show that most of the teenage pregnancies were unplanned 37 (60%) of the respondents and planned pregnancies were the least, 25(40%) of the respondents. This correlates to results from research done (Amon, 2017) in Kasese, Kilembe hospital where most teenage pregnancies80% were unintended.

From the study above, results indicate that the majority 46(74%) of the respondents were single by the time they got pregnant, and the minority 16(26%) of the respondents were already married. This implies that the majority of the respondents might have been engaged in other activities like education and therefore school dropout might have been the leading cause of their pregnancy these findings are similar to results reflected in Uganda's 2021 Annual Report that when Uganda entered her first COVID-19 lockdown and June 2021, there was a 17 percent increase in teenage pregnancies, especially in rural areas due to increased school dropouts.

### Social factors contribute to increased cases of teenage pregnancy.

The study findings showed that the majority42 (68%) of the respondents come from villages and a minority 8(13%) of the respondents come from cities, however, this correlated with results in UNICEF Uganda's 2021 Annual Report which were as, “when Uganda entered her first COVID19 lockdown and June 2021, there was a 17 percent increase in teenage pregnancies, especially in rural areas,”

The study findings indicate that the majority 34(55%) of the mothers had one parent still living and a minority 8 (13%) of the mothers had no single parent living this leads to poor parental guidance in most cases. These findings correlate to findings from research carried out by Manzi et al, 2018 that children in the adolescence stage who lack proper parental control are likely to engage in sexual activities hence getting pregnant.

Also, findings from the study indicate that there is a history of teenage pregnancy in families of most pregnant teenage mothers 35 (57%), and no history in the least of the pregnant teenage mothers, 27 (43%). Findings from the study indicate that the majority 26(42%) of the respondents were in good relationships with their parents well and the minority 4(6%) of the respondents were on bad terms with their parents. These results contradict with results from UNFPA, 2013 where teenage pregnancy was also influenced by the rejection of children by their parents. Parents who failed to provide for their children also contributed to the situation of teenagers falling pregnant at an early age. In another ward, Family disorganization may prompt family members to engage in deviant acts. When the family is dysfunctional, there is little or no love offered to the offspring in such households. Youth tend to seek love and affection elsewhere.

The study findings indicated that poverty was the highest factor that affected the majority 23(37%) of the respondents hence getting pregnant. Results from this study correlated with findings in research done by Gwido Vincent and Fekadu Mazengia Alemu, 2016 where Poverty contributed to early marriages as girls' families benefited from dowries (provided by the partner's family often as cattle) hence contributing to teenage pregnancy.

Early marriages were also another cause of increased cases of teenage pregnancy where 20(32%) of the respondents were pregnant. Results from this study are related to results obtained by Gwido Vincent and Fekadu Mazengia Alemu, 2016 where early marriages as girls' families benefited from dowries (provided by the partner's family often as cattle) hence contributing to teenage pregnancy. Similar results were obtained which indicated that 15% of the young women aged between 20-29 years were married at the age of 15, while 49% were married by the age of 18 in research done by Manzi et al. 2018.

Peer pressure has also been another contributing factor to teenage pregnancy where 8(23%) of the respondents fell pregnant before the age of 20 years. Results from this study are related to findings obtained by Ahinkora B. Et al, 2019 which indicate that Above average (61.3%) of adolescent girls responded that their peers influence them to engage in sexual intercourse, those whose parents would be happy if they got pregnant (86.7%) and those whose siblings will be happy if they got pregnant (87.1%) were those who were pregnant.

Results from the study also indicated that lack of parental guidance also led to an increase in teenage pregnancy where 4(7%) of the respondents were affected by this factor. These results corresponded to findings by Manzi et al. 2018 which revealed that 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 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.

The study above also indicated that 2(3%) of the respondents were raped. These results are related to results published by UNICEF, 2022 which showed that Increased crime rates for example defilement and Rape led to an increase in teenage pregnancy According to the 2021 Annual Police Crime Report, only 6,191 cases of defilement out of 14,436 cases reported in the previous year were taken to court.

## Health facility factors contribute to increased cases of teenage pregnancy.

Results from the study indicate that the majority48 (78%) of the respondents were aware of sexual and reproductive health services in nearby health facilities well and the minority 14(23%) of the respondents weren't aware of the availability of the services. These results contradict with findings by Muhwezi et al, 2015 that teenagers generally lack knowledge about sexual and reproductive health; this is mainly due to inadequate sex and reproductive education and poor parent-teenager communication, most of the teenagers also found it difficult to discuss Sex and Reproductive Health matters with parents. Also, research by Manzi et al. 2018, found similar results, for example only 3% of the respondents knew the minimum age at which a girl could get pregnant. As teenagers grow up, their curiosity about knowing more about sex increases, and also the extent to which they feel sexual pressure increases.

The study findings show that the majority44 (92%) of the respondents did not access sexual and reproductive health services well and the minority4 (8%) of the respondents accessed the services these results are related to results from research by Girls, not Brides, 2022 Which showed that girls face barriers to accessing contraception and safe abortion. This reduces their options for limiting or spacing their pregnancies. Barriers include judgment by health care providers and physical barriers – like distance and restricted mobility – to accessing clinics.

Results from the study indicate that all respondents62 (100%) knew about family planning. The study findings show that the majority57 (92%) of the respondents did not use family planning before they conceived well whereas the minority5 (8%) used it and conceived. Results from this

study correlate to findings in DHIS 2, 2017 which show that teenagers are reluctant to use contraceptives with very few utilizing the available services and those who used mostly preferred short-term contraceptives.

The research findings show that the majority (40%) of the respondents used pills and injection methods, 1(20%) used the condom method well and the minority 0(0%) used the withdrawal method. Findings from the research show that the majority 23(40%) of the respondents didn't use any family planning method before getting pregnant due to myths associated with family planning 22(39%) due to side effects,5(9%) due to fear of unfriendly health workers, 4(7%) due to religious beliefs, well as the minority3(5%) didn't use any family planning method because they wanted to deliver babies…These findings correlate to findings in research done by (Gueye et al., 2015) which asserted that in each country, the family planning myths most prevalent at the individual and community levels were that "people who use contraceptives end up with health problems," "contraceptives are dangerous to women's health" and "contraceptives can harm your womb." On average, women in Nigeria and Kenya believed 2.7 and 4.6 out of eight selected myths, respectively, and women in Senegal believed 2.6 out of seven. Women's individual-level belief in myths was negatively associated with their modern contraceptive use in all three countries (odds ratios, 0.2–0.7).

The study findings show that the majority (40%) of the respondents conceived due to poor pill adherence and misinformation about use well and the minority (20%) conceived when the implants were removed due to side effects.

## Conclusion

Of the 62 teenage mothers who participated in the study, the majority of the mothers were still in school by the time they got pregnant.

Among the individual factors, engaging in sexual intercourse at an early age and school dropout were the leading causes of teenage pregnancy, among the social factors, poverty was the leading cause of teenage pregnancy, whereas among the health facility factors, reluctance in family planning use was the leading cause to teenage pregnancy.

## Recommendations

Based on the findings, the study developed the following recommendations;

### To Ministry of Health (MOH):

- Should integrate more programs that target adolescent health.
- Should carry out timely support supervision on the adolescent health services in the healthcare setting.
- Develop a policy that allows adolescents to access contraceptives without discrimination.

### To Health Centre Management:

- The Hospital management should create a contraceptive distribution site for adolescents to prevent the fear of accessing the services.
- Hospital management should motivate staff and empower them with adolescents' friendly skills in handling adolescents to improve health workers' attitudes.

### To the Health workers:

- Health workers need to put more emphasis on sexual health education.
- They should carry out further research studies on the impact of teenage pregnancy on others, families, communities, and governments.

### To Community Members

- Institute bylaws to control sex abuse among adolescents.
- Promotion of girl child education and embrace Universal Primary Education/Secondary Education.
- Embracing of government poverty eradication program to improve household income.

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## LIST OF ABBREVIATIONS AND ACRONYMS

ANC**:** Antenatal Clinic

MCH: Maternal and Child Health

WHO**:** World Health Organization

UNFPA**:** United Nations Population Fund

NTIHC: Naguru Teenage Information and Health Centre

NAFCI: National Adolescent-Friendly Clinic Initiative

DIHS: District Information Health Software

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No conflict of interest declared

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