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A CROSS-SECTIONAL STUDY ABOUT FACTORS ASSOCIATED WITH TEENAGE PREGNANCY AMONG TEENAGE GIRLS AT KAYUNGA HOSPITAL KAYUNGA DISTRICT.

Phionah Namutebi, Joash Odiwuor Otieno, Denis dyamuhaki*
Medicare Health Professionals College.

ABSTRACT

Background

The purpose of the study was to determine the factors associated with teenage pregnancy among teenage girls at Kayunga Hospital Kayunga district. Specific objectives were to determine the knowledge of teenage girls toward teenage pregnancy and the socio-economic factors associated with teenage pregnancy among teenage girls.

Methods

A descriptive cross-sectional study was conducted among 100 teenagers in Kayunga Hospital Kayunga district. Data were collected using a structured questionnaire, entered, and analyzed appropriately.

Results

The majority of the respondent 69(69%) had not heard of teenage pregnancy whereas 31(31%) had heard. Most of the respondents 10(33.3%) sourced information about teenage pregnancy from school whereas 5(16.7%) from parents. The majority of the respondents 68(68%) stated that the father of the child is an elderly man whereas 32(32%) stated young man is the father. Peer pressure was the most cited reason for indulgence in sexual activities 45(45%), and culture accounted for 8(8%).

Conclusion

The results have presented a lack of knowledge among the teenagers as the majority have not heard of teenage pregnancy. The socio-economic factor predisposed most of the respondents to sexual activities.

Recommendation

Community sensitization, comprehensive sexuality education, and ensuring girls enroll and stay in schools could reduce adolescent pregnancy rates. Also, the provision of adolescent-friendly health services in schools and healthcare centers and the initiation of adolescent empowerment programs could have a positive impact.

Keywords; *Teenage, Pregnancy, Girls, Kayunga.*
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Corresponding author*: Denis dyamuhaki**
Email:kstardennis@gmail.com
Medicare Health Professionals College.

INTRODUCTION

Background

Globally, and largely in low and middle-income countries, an estimated 16 million young women aged 15 to 19, and about a million girls under 15 years of age give birth every year (Dick and Ferguson 2015). Each year, about 14 million pregnancies occur across sub-Saharan Africa, with nearly half of them occurring among women aged 15–19 years (UNFPA, 2013).

The prevalence of teenage pregnancy was reported to be about 16 million girls aged 15 to 19 years and mostly one million girls fewer than 15 years yearly in low- and middle-income countries. Also, childbirth complications during pregnancy are the second cause of death for 15-19-year-old girls WHO, 2014).

Teenage childbearing (intended or not) has adverse effects at the individual, community, and societal levels. Compared with their peers who delay childbearing, young women who have babies are less likely to finish high school, more likely to be poor as adults, and more liable to have kids who have poorer behavioral, educational, and health outcomes throughout their lives than do children born to adult parents (Cook and Cameron 2015).

Babies born to teenage mothers also face a substantially higher risk of dying than those born to women aged 20 to 24 (WHO, 2014). Approximately 95% of teenage pregnancies occur in developing countries with 36.4 million females becoming mothers before the age of 18 years (UNFPA, 2013).

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Sub-Saharan Africa recorded the highest prevalence of teenage pregnancy in the world in 2013 (UNFPA, 2013). Teenage births accounted for more than half of all the births in this region: an estimated 101 births per 1000 women aged 15 to 19. Sub-Saharan Africa consists of countries with prevalence of teenage pregnancy above 30% (Loaiza and Liang, 2013)

According to the World Atlas, 2017, Niger is on the top list of 203.604 births per 100,000 teenage women. Mali follows with 175.4438, Angola (166.6028), Mozambique (142.5334), Guinea (141.6722), Chad (137.173), Malawi (136.972), and Cote d'Ivoire (135.464). In Ghana, 14% of young women aged 15–19 had begun childbearing (GSS, 2015).

In Kenya, 18% of young women ages 15–19 have already begun childbearing; 15% are mothers and an additional 3% are pregnant with their first child. Young motherhood is slightly more common in urban areas than in rural areas, where approximately 30% of adolescent girls get pregnant in most urban centers. Most teenage pregnancies are unplanned and more likely to occur among poor and uneducated communities (MoH, 2015).

In Uganda 25% of teenagers aged 15-19 in Uganda have begun childbearing: 19% of women aged 15-19 have given birth, and another 5% were pregnant with their first child at the time of the interview. As expected, the proportion of women aged 15-19 who have begun childbearing rises rapidly with age, childbearing is more common in rural 27% than in urban 19% areas (UDHS, 2016). A report by DHIS, 2017, reported that a total of 11,025 mothers attended ANC first visits in the 16 health facilities in Kibuku District, of which 2,275 (25%). The study aims to determine the knowledge of teenage girls about teenage pregnancy at Kayunga Hospital Kayunga district.

METHODOLOGY

Study design

A descriptive cross-sectional study design was used to answer questions concerning the factors associated with teenage pregnancy among teenagers at Kayunga Hospital in Kayunga district. The purpose of using this design was to obtain data on different variables at a given point in time so that the variables are measured, and compared, and finally assisted in concluding the study findings.

Study area

The study was done at Kayunga Hospital in Kayunga district. The study was conducted in July 2023.

Study population

The study subjects were teenage girls who were present at Kayunga Hospital in Kayunga district.

Inclusion criteria

The consented respondents who were present at the Kayunga hospital in Kayunga district were included in the study.

Exclusion criteria

The study excluded respondents who had not consented and those who asked for enumeration were excluded from the study.

Sample size determination

The sample size was calculated using the Kish Leslie formula, with a prevalence of 46% of teenage pregnancy with an error margin (d) of 10%.

$$n = \frac{Z^2 \times P(Q)}{d^2}$$

Where: z = the standard normal deviation at 1.96 (which corresponds to a 95% confidence interval), p = the proportion of pregnant teenagers taken to be 46%, and Q = (1-P)

$$n = \frac{1.96^2 \times 0.46(1 - 0.46)}{0.1^2}$$

n=95.42respondents

The calculated sample size was 94. However, 6 respondents were added and the sample size used was 100

Sampling procedure

The researcher used a simple random sampling method; 10 days of the month were selected. The sample size of 100 was divided equally among the ten selected days resulting in 10 respondents from each day. Each of the selected days had ten papers labeled YES and the rest NO. Each respondent who picked YES and consented was interviewed. The same procedure was adopted in the 10 days until the end of the data collection.

Data collection tools

A self-administered questionnaire was administered to respondents. The questionnaire was developed in English based on the study objectives.

Data Collection Procedure

After obtaining informed consent, a questionnaire was administered to each respondent independently. Pieces of paper were written "yes" or "no" and then shuffled and those who were picked ones with yes were included in the study as participants. A fixed number of respondents was considered each day. This procedure was repeated every day till the required number of respondents was achieved.

Responses were written on the form in English. If the respondent cannot read and write or is not comfortable with the language, the researcher reads the questions and/ or translates the questions into the local language

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understandable to the respondent, and then the responses are written down.

Quality Control

To ensure that the right data is collected, the questionnaire was pre-tested on 10 respondents to find out whether the questionnaire was easily understood and answered as required. Mistakes detected were corrected. Also, research assistants were trained to help in data collection. The questionnaire was translated into suitable language to suit the respondents

Data presentation and analysis

Data was analyzed manually and presented in tables and figures

Ethical consideration

The research ethics committee of Medicare Health Professionals College provided the researcher with an introductory letter to the DHO who approved it. Through the DHO, it was addressed to the medical in-charge of Kayunga Hospital in Kayunga district who introduced the researcher to the study participants. The purpose of the study was explained to the respondents and requested assent to take part in the study.

STUDY FINDINGS

Socio-demographic data

Table 1: Distribution of respondents by socio-demographic characteristics n=100

Variable	Frequency	Percentage
Age in years		
14-16	25	25
17-19	75	75
Education level		
Primary	39	39
O level secondary	47	47
A level secondary	24	24
Employment status		
Employed full time	15	15
Employed part-time	30	30
Unemployed	55	55

Majority of the respondent 75(75%) were 17-19, whereas 25(25%) 14-16years. 47(47%) had attained O level of secondary education whereas 24(24%) A level of secondary education. The majority of the respondents 55(55%) had no employment while 15(15%) were employed full-time.

Knowledge of teenagers toward teenage pregnancy

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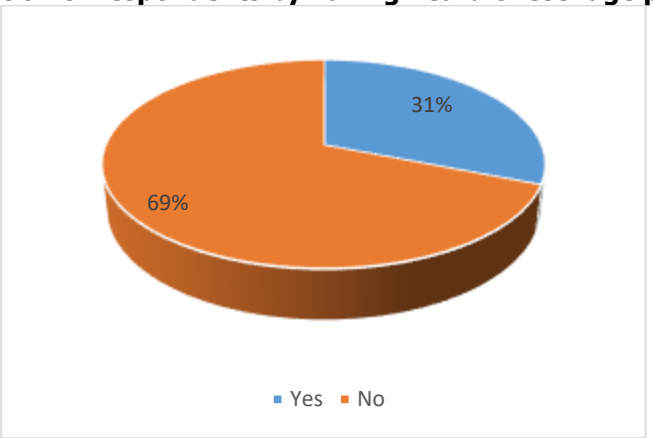
Figure 1: Distribution of respondents by having heard of teenage pregnancy n=100



Majority of the respondent 69(69%) had not heard of teenage pregnancy whereas 31(31%) had heard

Table 2: Distribution of respondents by source of information n=31

Source of information	Frequency	Percentage
Friends	7	23.3
School teacher	10	33.3
Media	8	26.7
Parents	5	16.7
Total	31	100

Most of the respondents 10(33.3%) sourced information about teenage pregnancy from school whereas 5(16.7%) from parents.

Table 3: Distribution of respondents by knowledge that a teenage girl can become pregnant on her first sexual encounter n=100

Response	**Frfrequency**	**Percentage**
Yes	34	34
No	45	45
Not sure	21	21
Total	**100**	**100**

Most of the respondents 45(45%) did not know that a teenage girl could become pregnant on her first sexual encounter whereas 21(21%) were not sure.

Table 4: Distribution by knowledge of signs of pregnancy n=31

Sign of pregnancy	**Frequency**	**Percentage**
Aches in the hips and back	6	19.4
Nausea experienced during pregnancy	18	58.
Abnormal vaginal discharge and spotted vision	7	22.6
Total	**31**	**100**

Most of the respondents 18(58%) knew that nausea was experienced during pregnancy whereas 6(19.4%) knew the presence of aches in the hips and back as a sign of pregnancy.

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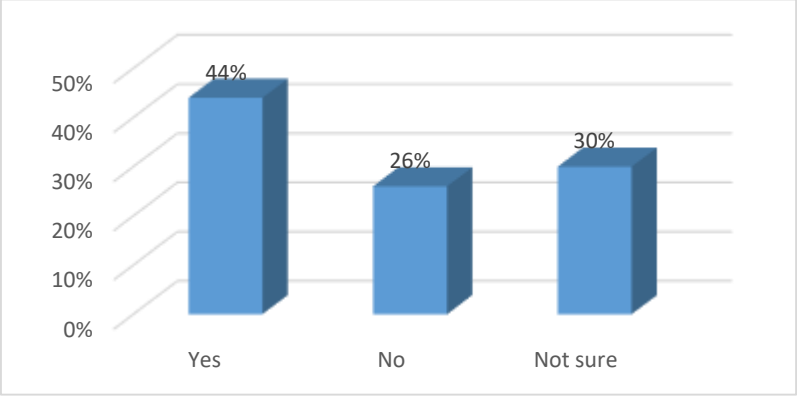
Figure 2: Distribution by knowledge that contraceptives prevent pregnancy n=100



Most of the respondents 44(44%) knew that contraceptives prevent pregnancy while did not know.

Socio-economic factors associated with teenage pregnancy

Table 5: Distribution by the father of the child n=100

Response	Frequency	Percentage
Young man	32	32
An elderly man	68	68
Total	100	100

MA majority of the respondents 68(68%) stated that the father of the child is an elderly man whereas 32(32%) stated young man is the father.

Table 6: Distribution by what necessitated indulgent into sexual activities n=100

Response	**Frequency**	**Percentage**
Money	37	37
Low income of the parents	10	10
Culture	8	8
Peer pressure	45	45
Total	**100**	**100**

Peer pressure was the most cited reason for indulgence in sexual activities 45(45%), and culture accounted for 8(8%).

Table 7: Distribution by use of illegal drug before conceiving n=100

Response	Frequency	Percentage
Yes	36	36
No	64	64
Total	100	100

The majority of the respondent 64(64%) had not used any illegal drug before conceiving whereas 36(36%) had used illegal drugs.

DISCUSSION

Knowledge of teenagers toward teenage pregnancy

The majority of the respondents 69% had not heard of teenage pregnancy whereas 31% had heard. This is slightly in line with a study by Manzi et al., 2018, which reported that 72% of the respondents had ever heard about teenage pregnancy as compared to the 24% who had never heard about it.

Most of the respondents 33.3% sourced information about teenage pregnancy from school, 26.7% sourced from the media, 23.3% from friends, and 16.7% from parents. This is

attributed to the fact that most of the teenagers were engaged in discussing health education in school, media is easily accessed hence the information flows. Based on the source of information, this study differs from Akinwumi et al., 2018, which reported that 12.3% of the respondents obtain information about sex from their parents/guardian, 9.5% obtain such information from either their school teachers or physicians, 24.6% rely on their friends for information about sex and the remaining majority 53.6%, rely on media for information about sex.

The changes that occur during the teenage period expose the girls to pregnancy in the first encounter, however, 45% of the respondents did not know that a teenage girl can become pregnant on her first sexual encounter 21% were not sure, only 35% of the respondents knew that they can get pregnant in the first encounter. This is similar to a study by Manzi et al., 2018, which showed that only 48% of the respondents understood that a girl could become pregnant on her first sexual intercourse as compared to the 52 % who either believed a girl couldn't get pregnant on her first sexual encounter or were not sure.

Just like any other condition, pregnancy also has signs and symptoms. The majority of the respondents 58% cited nausea experienced during pregnancy, 22.6% abnormal vaginal discharge and spotted vision, and 19.4% Aches in the hips and back as signs of pregnancy. This is contrary to a study by Govender et al., 2019, that reported 72.1% correctly identified that aches in the hips and back are normal symptoms during pregnancy. The results showed that 5.8% of the participants did not know that nausea was experienced during pregnancy. Only 43.9% and 23.3% correctly identified that an abnormal vaginal discharge and spotted vision were abnormal symptoms during pregnancy respectively.

Contraceptives are meant to prevent one from getting pregnant, this was acknowledged by most of the respondents 44% as they knew that contraceptives prevent pregnancy 30% were not sure and 26% did not know. This is similar to a study by Layu Donatus et al., 2018, which reported that 78% of the respondents knew that contraceptives prevent pregnancy as well as other sexually transmitted infections.

Socio-economic factors associated with teenage pregnancy

Elderly men tend to prey the innocent teenage girls which ends up in pregnancy. This is evident as most of the respondents 68% stated that the father of the child is an elderly man whereas 32% stated a young man is the father. This is similar to a study by Study by Matodzi 2015 that showed that 50% of the participants confirmed that the fathers of their babies were elderly people.

Peer pressure was the most cited reason for indulgence in sexual activities 45%, 37% opted for money for sex, and culture accounted for 8%. This is in line with a study by Study by Okechukwu, Ngwu, and Ajibo, 2018, which showed that 17.6% of the respondents stated that the low-income status of parents promotes teenage pregnancy, 18.7% of the respondents indicated illiteracy, 1.5% of the respondents said culture, 4.7% said residence, while 10.9% said peer pressure.

The majority of the respondents 64% had not used any illegal drug before conceiving whereas 36% had used illegal drugs. It is very hard to control one's feelings once under illicit drugs hence the indulgence in sex, resulting in pregnancy, however majority of the respondents had been not under the influence of drugs. This study is in agreement with Alabi and Oluwafemi, 2017, who that stated drinking lowers a teen's ability to control her impulses, contributing to 75% of pregnancies that occur between the ages of 14 and 21.

Conclusion

The results have presented a lack of knowledge among the teenagers as the majority have not heard of teenage pregnancy. The socio-economic factor predisposed most of the respondents to sexual activities.

Recommendation

Community sensitization, comprehensive sexuality education, and ensuring girls enroll and stay in schools could reduce adolescent pregnancy rates. Also, the provision of adolescent-friendly health services in schools and healthcare centers and the initiation of adolescent empowerment programs could have a positive impact. Information on the sexual and reproductive health of teenage girls, improving access to and information about contraceptive use among teenage girls, improving the socio-economic status of households, and law enforcement on sexual abuse among girls may come a long way to improving adolescent sexual and health services in low-income settings.

Acknowledgment

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Special thanks go to my lovely father and mother for their endless support both financially and emotionally throughout the whole process of conducting this research.

List of Abbreviations and Acronyms

NGOs: Non-governmental organizations
UNFPA: United Nations Population Fund
WHO: World Health Organization
UAHEB: Uganda Allied Health Examination Board
MHPC: Medicare Health Professionals College
DHO: District health officer
MoH: Ministry of Health

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No source of funding.

Conflict of interest
No conflict of interest.

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