



**Prevalence and factors associated with teenage pregnancy among pregnant mothers attending Rakai General Hospital, Uganda: A cross-sectional study.**

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**Abstract**

**Background:**

The World Health Organization defines a teenage pregnancy as a pregnancy below the age of 20 years, and it is a major public health concern affecting more than 16 million girls and young women around the world. This study aimed at determining the Prevalence and Factors associated with Teenage Pregnancy among Mothers attending the Antenatal Care Clinic at Rakai General Hospital.

**Methods:**

It was a cross-sectional study where we included pregnant women attending ANC. Using a consecutive sampling method, 251 pregnant women were enrolled. Data was collected using structured pre-tested questionnaires and analyzed using STATA Version 15.1. A bivariate and multivariate analysis was used to show the association between the dependent and independent variables, considering  $P < 0.05$  as the level of significance and the 95% confidence interval.

**Results:**

The prevalence of Teenage Pregnancy was 55(21.91%). Mothers with no formal education were 5.8. times more likely to have teenage pregnancy with (aOR =5.8.0; 95% CI = [1.759-19.675];  $P=0.004$ ), girls in Peer groups were 3.1 times more likely to have pregnancy in their teenage age with (aOR =3.1; 95% CI = [1.946-12.633];  $P=0.016$ ), history of contraception use and age of marriage less than 18 years were also significantly associated with Teenage pregnancy amongst mothers attending Rakai General Hospital Antenatal Care Clinic with, (aOR =3.2; 95% CI = [1.731-13.326];  $P=0.001$ ); (aOR =3.9; 95% CI = [1.693-10.075];  $P=0.013$ ) respectively.

**Conclusion**

The overall prevalence of Teenage pregnancy is high compared to the global prevalence. Teenage Pregnancy was significantly associated with no formal education, peer groups, a history of contraception use, and an age of marriage of less than 18 years.

**Recommendations**

Conduct a national study on the prevalence, strengthen laws against early marriage, keep girls in school, and sensitize them on teenage pregnancy risks.

**Keywords:** Prevalence, Teenage Pregnancy, Rakai General Hospital, Pregnant Mothers

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**Introduction**

Teenage pregnancies are a major global public health concern due to their associations with social, psychological,

and serious obstetrical complications to underage mothers [1]. According to the World Health Organization, a Teenage pregnancy is defined as the occurrence of pregnancy among girls aged 10-19 years [2]. Reasons for the increased teenage



pregnancy rate in developing countries are multifactorial, including behavioral, traditional, social, educational, and religious bases [3]. Media influence, lack of contraception, and poverty have been associated with an increased number of teenage pregnancies [4]. A study done in Ethiopia showed that Age 16–17 years old, not being in school, lack of formal education, being married, parental divorce, having an elder sister who had a history of teenage pregnancy, and not knowing the fertile period in the menstrual cycle were independently associated with teenage pregnancy [5].

Different factors have been associated with teenage pregnancy in Uganda. In the Agogo district, factors significantly associated with teenage pregnancy were alcohol consumption and having secondary/tertiary education [6]. While in Arua, contraceptive nonuse, peer pressure, alcohol, cultural norms, family neglect, adolescent's education level, and adolescent's poor social status were found to be significantly associated with teenage pregnancy [7]. Teenage pregnancy is associated with a higher number of obstetrical and perinatal complications than non-teenage mothers, including preterm birth, severe pre-eclampsia, antepartum hemorrhage, and pre-labor rupture of membrane, cesarean sections, major degree perineal tear, preterm labour and iron deficiency anemia, low-birthweight, intrauterine death, and admission to neonatology [2], [8].

Globally, approximately 16 million adolescent girls aged 15–19 years and 2 million adolescents under the age of 15 years give birth annually in the world [9]. The prevalence is high in Africa, whereby approximately one-third of teenagers become pregnant [10]. A study done in East Africa demonstrated that approximately half of teenagers become pregnant [11]. Studies done in Uganda demonstrated a higher rate of teenage pregnancy, though it varies among different regions. It was 20.6% in Mbale [12], 22.7 % in Arua district [7], 30.6% in Hoima [13], and 35.8% in Kibuku District [14]. Despite registering cases of teenage pregnancy in the Rakai district, the burden of teenage pregnancy is not known in the Rakai general hospital. Therefore, it is important to determine the prevalence and factors associated with teenage pregnancy among pregnant mothers attending Rakai general hospital.

## Materials and Methods

### Study design and setting

A cross-sectional study between March 2025 and June 2025 from the antenatal care clinic and the maternity ward of Rakai General Hospital (RGH), whereby consecutive

enrollment was used. RGH is a government hospital located in Rakai district in central Uganda, approximately 65 kilometers southwest of Masaka city. Rakai district borders Lyantonde district to the northwest, Lwengo District to the North, Kyotera District to the northeast, Kalangala District to the east, the Kagera region in the Republic of Tanzania to the south, Isingiro district to the southwest, and Kiruhura district to the northwest. The hospital has a 100-bed capacity for inpatients and is composed of different departments offering both outpatients and inpatients. The antenatal care clinic is run from Monday to Friday and is currently receiving between 15 and 20 pregnant mothers per day. The department of obstetrics and gynecology of Rakai general hospital has one full-time gynecologist, 5 medical officers, midwives, and nurses. It has sub-departments, including Outpatient, family planning, antenatal care, gynecology ward, postnatal ward, and labor suite. The hospital conducts between 6 and 8 deliveries per day.

### Data Collection Procedure

The data used for analysis were collected by the principal investigator (PI) and trained research assistants from patient interviews and charts using a pretested questionnaire. Data collection instruments were pretested at the Rakai general hospital. Eligible women were provided with detailed information regarding the study and consented to participate in the study.

### Sample size calculation

(Daniel, 1999) The formula was used to calculate the sample size:

Where:

$n$  = required sample size estimate

$Z$  = critical value for normal distribution at 95% confidence level, corresponding to 1.96

$P$  =  $P$  = estimated prevalence rate, which is 20.6% from a study done in Uganda, Mbale Regional referral hospital (Chemutai et al., 2022).

Therefore,

= 251 participants

### Data analysis

Information from each questionnaire was summarized in Microsoft Excel version 19, coded, and transferred into STATA version 15.1 for analysis. Descriptive statistics were performed to determine the baseline characteristics of participants, prevalence of teenage pregnancy among pregnant mothers at ANC and maternity ward, and

associated factors were determined using Binary logistic regression analysis. Bivariate analysis at a 95% confidence interval was done, and factors with  $P \leq 0.2$  were analyzed further at the Multivariate level to remove confounders, and those that had  $P \leq 0.05$  were considered significant in this study.

### Ethical considerations

This research project was approved by the research ethics committee of Bishop Stuart University and the administration of Rakai General Hospital. The study was registered with the Uganda National Council for Science and Technology (UNCST). All study participants were provided written informed consent. All ethical standards were followed.

## Results

### Characteristics of the study participants

A total of 251 pregnant mothers participated in this study. The age of the study participants ranged between 14 and 40 years, and the majority were 21 to 25 years, 90(35.86%). Many of them had attained a primary level of education 133, 52.99%, and most were married 163, 64.94%). Most were from Rural residences, 188(74.90%), the majority were in peer groups, 136 (54.18%), and Christian, 154(61.35%). Few of them had history of contraception conception use 100(39.84%), Family history of Teenage pregnancy

80(31.87%), Knowledge about menstrual cycle 58(23.11%) and majority started marriage  $\geq 18$  years 152(60.56%) and started coitus at  $\geq 15$  years 159(63.35%).

### Table 1.

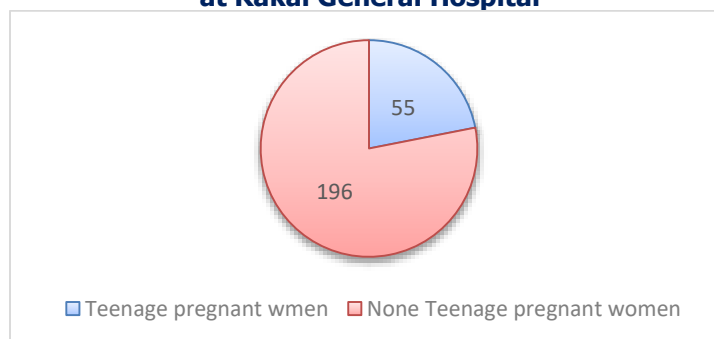
Out of 251 mothers who participated in this study, 55(21.91%) of them were teenage mothers as shown in figure 1

To identify factors associated with Teenage pregnancy, Univariate analysis carried out revealed that no formal education, rural residence, smoking, drinking alcohol, Peer groups, history of contraception use, age at initiation of sexual intercourse of  $\geq 15$  years, and early marriage  $< 18$  years were significant.

On Multivariate analysis, after removing confounders Mothers with no formal education were 5.8 times more likely to have teenage pregnancy compared to those who had formal education with (aOR =5.8.0; 95% CI = [1.759-19.675];  $P=0.004$ ), girls in Peer groups were 3.1 times more likely to have pregnancy in their teenage age compared to those no in peer groups with (aOR =3.1; 95% CI = [1.946-12.633];  $P=0.016$ ), history of contraception use and age of marriage less than 18 years were also significantly associated with Teenage pregnancy amongst mothers attending Rakai General Hospital Antenatal Care Clinic with, (aOR =3.2; 95% CI = [1.731-13.326];  $P=0.001$ ); (aOR =3.9; 95% CI = [1.693-10.075];  $P=0.013$ ) respectively.

### Table 2.

**Figure 1: Prevalence of teenage pregnancy among mothers attending Antenatal Care Clinic at Rakai General Hospital**





**Table 1: Characteristics of the study participants**

Variable	Category	Frequency(n)	Percentage
<b>Socio-demographic characteristics</b>			
Age	< 15	7	2.79
	15-20	66	26.29
	21-25	90	35.86
	>25	88	35.06
Level of education	At least Secondary	72	28.69
	Primary	133	52.99
	No Formal education	46	18.32
Marital status	Single	88	35.06
	Married	163	64.94
Parents' level of education	No Formal education	56	22.31
	Primary	111	44.22
	At least Secondary	84	33.47
	Rural	188	74.90
Residence	Urban	63	25.10
Smoking	Yes	26	10.36
	No	225	89.64
Drinking alcohol	Yes	34	13.55
	No	217	86.45
Drugs/substance abuse	Yes	42	16.73
	No	209	83.27
Peer groups	Yes	136	54.18
	No	115	45.82
Religion	Muslim	97	38.65
	Christian	154	61.35
<b>Gynecologic/Obstetric characteristics</b>			
History of contraception use	Yes	100	39.84
	No	151	60.16
Family history of Teenage pregnancy	Yes	80	31.87
	No	171	68.13
Knowledge about the menstrual cycle	Yes	58	23.11
	No	193	76.89
Age at initiation of sexual intercourse	<15	92	36.65
	≥15	159	63.35
Age of marriage	<18	99	39.44
	≥18	152	60.56

**Table 2: Multivariate analysis of Factors Associated with Teenage Pregnancy among Pregnant Mothers Attending the Antenatal Care Clinic at Rakai General Hospital.**

Variable	Category	cOR(95%CI)	P <sup>1</sup>	aOR (95%CI)	P <sup>2</sup>
Level of education	At least Secondary	1.00			
	Primary	0.7(0.245-1.394)	0.708	1.4(0.332-5.251)	0.612
	No Formal education	2.9(1.862-8.104)	<b>0.033</b>	5.8(1.759-19.675)	<b>0.004</b>
Residence	Urban	1.00			
	Rural	2.7(1.574-6.153)	<b>0.005</b>	0.9(0.489-2.921)	0.143
Peer groups	No	1.00			
	Yes	6.9(4.460-14.627)	<b>0.001</b>	3.1(1.946-12.633)	<b>0.016</b>
Smoking	No	1.00			
	Yes	2.4(1.671-5.224)	<b>0.032</b>	1.9(1.351-3.087)	0.082
Drinking alcohol	No	1.00			
	Yes	4.8(1.491-5.307)	<b>0.008</b>	0.8(0.312-2.087)	0.315
History of contraception use	No	1.00			
	Yes	4.5(1.829-9.128)	<b>0.004</b>	3.2(1.731-13.326)	<b>0.001</b>
Age at initiation of sexual intercourse	<15	1.00			
	≥15	6.0(3.118-14.336)	<b>0.001</b>	1.0(0.791-3.926)	0.095
Age of marriage	≥ 18	1.00			
	< 18	5.2(2.984-11.677)	<b>0.001</b>	3.9(1.693-10.075)	<b>0.013</b>

cOR: Crude Odds Ratio, CI: Confidence Interval, aOR: adjusted Odds Ratio, P<sup>1</sup> is p values ≤ 0.2 before aOR, P<sup>2</sup>: ≤0.05 with aOR,

## Discussion

In this study, the prevalence of Teenage pregnancy was 21.91%. Study findings were almost similar to that conducted in Nepal and India 21% and 21%, respectively [15]; that conducted by Asmamaw et al (2023) in sub-Saharan Africa, which demonstrate the prevalence of teenage pregnancy of 24.88% [16] and that carried out by Kassa et al (2018) East Africa 21.5% [17], 24.3% in Nyatike Sub-county Kenya [18], 23.3% in cross section study done in rural western Kenya [19]; 22.7% and 20.6% in a study conducted from Arua district, Pajulu Sub County and Mbale Regional Referral Hospital respectively in Uganda [7], [12]. This is attributed to the fact that we used almost the same sample size and study design; also, it could be due to the similar sociocultural behavior of young girls getting married at an early age.

However, the prevalence from this study is much higher than that found in systematic review and meta-analysis study

conducted by Varmaghani et al (2024) which was 9% [20], 10.1% in Turkey [21], 16 % in Latin America [22]; 18.8% in a systemic review and meta-analysis study done in Africa [17], and 18.15% pooled prevalence of teenage pregnancy in a cross sectional study conducted in sub-Saharan Africa [23], 7.7% in Nigeria [24] and 7.2% in Rwanda [25]. Then 2.8% in a Community-Based Survey done in Agago district, Uganda [6]. These differences are attributed to the fact that in these studies, a smaller sample size was used, and it could also be due to differences in study design, environment, culture, economy, and social behaviors.

The overall prevalence of Teenage pregnancy in our study was lower than the worldwide prevalence of Teenage Pregnancy, which is about 25% [26]. It was also lower than that in a study conducted in Bangladesh, 35% [15], 42.5% in Pakistan [27], 33% in a systemic review and meta-analysis study done in Western Africa [10], 44.3% in Congo [25], 53% in South Africa [28], 50.2% in Liberia [29],



30.2% in a community-based cross-sectional study conducted in Ethiopia [5], 29 to 48% in a systematic review conducted in Zambia [30] and 54.6% in East-African countries [11] where Tanzania had 29 % [31] and in Uganda, across-sectional study conducted in Kibuku district showed the prevalence of teenage pregnancy of 35.8%; then a cross sectional Community-based study done in Hoima it was 30.6% [13]. These differences could be because these studies used a very large sample size. And also different cultural beliefs of marrying young girls, different in socioeconomic status.

No formal education, was significantly associated with Teenage pregnancy, similar findings were found in a study conducted in Pakistan, where educational level attained by a girl influenced the likely hood of becoming pregnant at earlier age [27], Diabelkov et al (2023) revealed that being uneducated was 16.8 times more likely to get unwanted pregnancy at an early age compared to adult [32], also Abate et al (2025) revealed that Level of education was significantly associated with teenage pregnancy [33]. Similarly in a cross sectional study conducted in sub-Saharan Africa, they found that, the status of education was significantly associated with Teenage pregnancy [23], according to a cross-sectional study conducted by Mezmur et al (2021) in Ethiopia, not being in school/no formal education was independently associated with teenage pregnancy [5], that conducted in Rwanda, revealed that being out of school (AOR = 23.76,  $p < 0.001$ ) was associated with Teenage pregnancy [26]. According to Faith et al (2025), lack of formal education was associated with Teenage pregnancy [34].

A study conducted by Nagandla & Kumar (2020) revealed that a mother's educational status was associated with teenage pregnancy [2]. A study done in Nigeria found that the lack of formal education significantly increased the vulnerability of girls to becoming pregnant [24]. In Uganda, a study done showed that the primary level of education increased the likelihood of teenage pregnancy [12]. It was, however, contrary to a study according to Worku et al, who found that attaining secondary education and above was a factor associated with Teenage pregnancy [11]. This is attributed to the fact that if girls go to school, they can get information on reproductive health behavior and its consequences, and how to prevent them, unlike those who do not go to school. They are also more engaged in studying, which helps keep them busy so that they do not participate in sexual behaviors.

Peer groups were associated with teenage pregnancy. Similar findings were in the study conducted in Dodoma, Tanzania, which revealed that Peer group was significantly associated with teenage pregnancy [31], and also in Rwanda, peer pressure (AOR = 4.12,  $p < 0.01$ ) was associated with Teenage pregnancy [34]. Many teenagers are not taught about methods of birth control and how to deal with peers who pressure them into having sex before they are ready [4]. Another study conducted by Letaru demonstrated that peer pressure was significantly associated with adolescent pregnancy [7]. This is attributed to the fact that, when girls are with those who have tried to do some practices like sex, they will influence others to do the same, for example, sexual activities.

History of contraception use was less likely associated with Teenage pregnancy similar findings were observed in the study conducted in India, in which lack of knowledge on contraceptives is potential pathways leading to adolescent pregnancy [35], in a systematic review and Meta-analysis study conducted by Abate et al (2025) also revealed that, none contraceptive use was significantly associated with teenage pregnancy [33], according to a study conducted by Bennetsen et al (2023), none contraceptives use was associated with Teenage pregnancy [36], however, according to Mekonen (2024), use and knowledge about contraceptive was negatively associated with Teenage pregnancy (Mekonen, 2024). Also in Liberia by Sinnatwah et al (2024), not using contraception was significantly associated with Teenage pregnancy [29]. This is because when these girls are using contraceptives, they practice sex frequently, and in case the method fails, the chances of getting pregnant are high. In Zambia, exposure to media, knowledge about sexual and reproductive health and contraception, contraceptive use, as well as risky sexual behaviors were found to be significantly associated with adolescent pregnancy [30]. In Uganda, a study done showed that a history of ever use of contraceptives and exposure to sex education at home decreased the likelihood [12]; another study demonstrated that contraceptive nonuse was significantly associated with adolescent pregnancy [7]. Age of marriage less than 18 years was significantly associated with Teenage pregnancy. Similar findings were in the study conducted in India, in which early marriage was potentially leading to adolescent pregnancy [35]. Also, Nagandla & Kumar (2020) noted that being married before the age of 18 was associated with teenage pregnancy [36]. A study conducted in Dodoma, Tanzania, revealed that early marriage was significantly associated with teenage





pregnancy [36]. According to Faith et al (2025), early marriage was associated with Teenage pregnancy [36]. A study done in Nigeria found that early marriage significantly increased the vulnerability of girls to becoming pregnant [24]. This is a common practice in some regions in Africa, including Uganda, where young girls are sent to marriage at an early age as a result of poverty.

### Conclusion.

The overall prevalence of Teenage pregnancy is high compared to the global prevalence. No formal education, peer groups, history of contraception use, and age of marriage less than 18 years were independent factors associated with Teenage pregnancy.

### Study strengths and limitations

This study looked at the association, not the causation.

### Recommendations

Recommend carrying out a national study in this country to establish the prevalence in the general population, to help curb this burden, and also to strengthen and implement rules against early marriages, encourage all young girls to be in school, and sensitize them about peer groups and dangers associated with teenage pregnancy.

### Abbreviations

ANC: Antenatal Care  
IUGR: Intrauterine growth restriction  
OPD: Outpatient department  
PIH: Pregnancy-induced hypertension  
SSA: Sub-Saharan Africa  
STDs: Sexually transmitted diseases  
STIs: Sexually transmitted infections  
WHO: World Health Organization  
BSU: Bishop Stuart University

### Availability of data materials

The dataset that was used and analyzed in this study is publicly available from the library of BSU. Upon reasonable request, the Dataset used is also available to all authors (email: happytukirinawe@gmail.com).

### Contributions of authors

Happy Tukirinawe developed the proposal, participated in data collection, and performed data analysis. Musinguzi Ronard had a significant contribution in data collection,

analysis, and drafting of the manuscript. Associate Professor Kazibwe Francis and Dr.Gladys Nakidde participated in making corrections to the proposal and analysis process. Rukamba de Dieu Jean, Edward Niwamanya, and Dr Bonny Nowomuhangi had contributed to data collection, entry, analysis, and revision of the manuscript. All authors read and approved the final manuscript.

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### Competing interests

The author declares no competing interests.

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