

**TEENAGE PREGNANCY AND ITS ASSOCIATED FACTORS AMONG GIRLS  
SEEKING CARE FROM IGANGA GENERAL HOSPITAL: A POST-COVID ERA  
PERSPECTIVE**

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**UGANDA CHRISTIAN  
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## DECLARATION

I Acheng Barbara Brenda declare that this research titled teenage pregnancy and its associated factors among girls seeking care from Iganga general hospital: a post-covid era perspective is my original work. It has never been submitted in part or full to any other institution for any academic qualification.

This study was conducted in adherence to ethical research guideline and all necessary approvals and consents were obtained from relevant authorities and participants. No part of this project should be reproduced without my consent.

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**SUPERVISOR'S APPROVAL**

This research Dissertation has been submitted for examination with approval from the University Supervisor.

Signature:  .....

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## **List of abbreviations**

MoES	Ministry of Education and Sports
SRH	Sexual and Reproductive Health
UK	United Kingdom
UNICEF	United Nations Children Fund
UNFPA	United Nations Fund for Population Activities

## **Abstract**

**Introduction:** Teenage pregnancy remains a global public health problem of concern among teenage girls and their children's health and well-being with an annual number of 21 million girls aged from 15 to 19 years in developing regions becoming pregnant. Uganda with the highest rates of teenage pregnancies in sub-Saharan Africa, estimated at about 25% possess a serious problem on the health sector and the communities where teenage pregnancies contribute to 20% of infant deaths and 28% of maternal deaths.

**Objective;** The aim of this study was to assess the prevalence of teenage pregnancy and its associated factors among teenage girls seeking care at Iganga General Hospital Iganga District

**Methods:** A cross-sectional study was conducted among 292 teenage girls seeking care at Iganga General Hospital Iganga District in August 2024. An interviewer-administered questionnaire instrument was used to collect data, allowing for a snapshot assessment of the social demographic characteristics, knowledge, and sexual behaviors, family and societal factors related to teenage pregnancy. During sampling, consecutive sampling technique was used to select teenage girls who were found seeking care at Iganga General Hospital. Data were analyzed using STATA version 15, applying descriptive statistics and modified Poisson regression to assess independent associations with teenage pregnancy while reporting prevalence ratios as the measure of association.

**Results:** The prevalence of teenage pregnancy among the 292 teenage girls seeking care at Iganga general hospital was 57.5% (n=168; 95%-CI: 51.64-63.27) Perceived knowledge on contraceptives with limited knowledge (aPR1.28 95%-CI:1.039-1.580, p-value=0.02), Employment status of participant with non-employed (aPR:1.37 95%-CI:1.008-1.858, pvalue:0.044) and Age at first

sexual intercourse with age >17yrs (aPRr:0.65 95%CI:0.492-0.863, p-value=0.003) were significantly associated with teenage pregnancy.

**Conclusion** At Iganga General Hospital, the findings revealed that about 60% of the girls had been pregnant as teenagers. Employment position, age at first sexual encounter, and perceived understanding of contraceptive use are important factors linked to this problem. The implementation of community-wide programs that offer thorough sexual education in schools and nearby medical facilities, emphasizing safe sex, contraception, and the consequences of early pregnancies, is advised as a solution to this problem.

Key words; Teenage pregnancy, perceived knowledge, sexual intercourse, informed decision

## **Definition of Terms**

**Teenage:** The World Health Organization (WHO) defines adolescence as the period between the ages of 13-19 years.

**Teenage pregnancy:** Teenage pregnancy was defined as pregnancy in a female teenager between the ages of 13 to 19 years.

**Prevalence:** Is the total number of people who have a condition in a certain group at a specific time

**Routine Care:** refers to the regular, preventative, and maintenance healthcare services provided to individuals to ensure overall health and well-being. It typically includes services such as: Preventive check-ups, Vaccinations, Immunizations, Health education, Mental health screenings, Family Planning, ANC,PNC.

## CHAPTER ONE

### 1.1 INTRODUCTION

**Teenage** pregnancy is a global problem and creates issues for all those concerned about young girls and their children's health and well-being. Annually, about 21 million girls aged from 15 to 19 years in developing regions become pregnant (WHO, 2024a, 2024b) . Vulnerability to pregnancy during teenage years in developed countries is primarily related to the use of effective contraception which is promoted through social background factors such as sexuality education and access to youth friendly Sexual Reproductive Health services and most teenage pregnancies in Europe are unplanned, resulting in many cases in pregnancy termination(WHO, 2024a, 2024b) Around half of these pregnancies were unintended, and more than half ended in abortion, often in unsafe conditions (WHO, 2024b).

Teenage pregnancy is a major public health problem, particularly in Africa,(Maheshwari et al., 2022; Tesfa et al., 2023; Webb et al., 2023); it is associated with high maternal and child morbidity and mortality and affects the socioeconomic development of a country (Popoola, 2021). It is linked to an increased risk of adverse pregnancy and childbirth outcomes compared to older women. More than 70,000 teenage girls die every year because of these complications mainly in developing countries. Most maternal and child morbidity and mortality are related to hypertensive disorders of pregnancy, infections, low birth weight, and preterm delivery (Saleh, 2022). Teenage pregnancies are persistently high among teenage women in high fertility countries in sub-Saharan Africa and it has been attributed to the high unmet need for family planning in this population (Belachew et al., 2022; Maharaj, 2022). Pregnancy among teenagers has implications on the educational opportunity, population growth and ill-health of women (Aisevbonaye, 2022).

Teenage pregnancy is among the major healthcare system problems that should be addressed since early pregnancy can have long-lasting harmful implications on girls' physical, psychological, economic and social status and it is a concern from both human rights and public health perspectives and it is also a media-focal-point and a major issue irrespective of the teenager's marital status (Sama et al., 2017; Tridenti & Vezzani, 2017). Preventing teenage pregnancy can help this goal since it is associated with poor maternal and child health outcomes and increased risks of dying during pregnancy (Amjad et al., 2019; Nguyen et al., 2019).

Early pregnancies remain a significant concern in Uganda, in 2020, there was a marked increase in teenage pregnancy in 67 out of the 136 districts in the country (UNPFA, 2021).

In the period from March to September of 2020, when schools in Uganda were partially closed on account of Covid-19 restrictions, there was a 366 percent increase in pregnancies among girls aged (UNPFA, 2021)

10-14 years. The numbers of teenage pregnancy were highest in districts of Wakiso (10,439),

Kampala (8,460), Kasese (7,319), Kamuli (6,535), and Oyam (6,449) and 6,205 Mayuge (UNPFA, 2021). Teenage pregnancy is more common in rural than in urban areas at 27 per cent against 19 percent, respectively implying that young girls in rural areas have almost twice as many births as their counterparts in urban areas. Teenagers in the lowest wealth quintile tend to begin childbearing earlier than those in the highest quintile ("The National Strategy to End Child Marriage Teenage Pregnancy 2022/2023 -2026/2027," 2022) where cultural, social, and economic elements overlap, with consequences for the wellbeing of girls and the country's educational system. With a focus on Iganga District specifically, which is among the leading districts in Uganda with teenage pregnancy

cases with 21% of all teenage

Pregnancies (UNPFA, 2021), this study begins a thorough investigation of the up-to-date prevalence of teenage pregnancy its associated factors on teenage girls seeking care at Iganga General Hospital.

## **1.2 Background**

Teenage pregnancy, which varies globally, is defined as a girl falling pregnant when she is between the ages of 13 and 19 and usually refers to girls who have not attained legal maturity. Globally, it is regarded as a severe public health and social issue, with 95% of cases occurring in underdeveloped nations (WHO, 2024b). Teenage pregnancy is a growing public health problem contributing to primary and secondary school dropout and pregnancy rates of teenagers remains the highest among western industrialized countries nations, with the united nations population division estimates that 222 million women worldwide would like to prevent pregnancies but are not using contraceptives, that's why every year 16 million girls give birth and 50% of them are from Africa according to the United Nations Children Fund ("Adolescent pregnancy [https://data.unicef.org/topic/adolescents,](https://data.unicef.org/topic/adolescents)" 2018). Uganda has one of the highest teenage pregnancies in sub-Saharan Africa, estimated at about 25% pregnancies among teenagers registered every year (WHO, 2024b). Within the same country there are differences in the proportion with Lira District having the highest rate in northern Uganda (Nabugoomu, 2019; Ochen et al., 2019a)

In addition to physical changes, young girls' bodies undergo additional vulnerabilities with the biological onset of puberty, especially in the areas of sexuality, marriage, and motherhood. According to the Uganda Demographic Health Survey report, 24% of female teenagers are either pregnant or have given birth, reflecting a rise in child pregnancies to 25% (UBOS, 2022). Like in many other nations, adolescent pregnancies surged in Uganda as a result of COVID-19. Girls have

engaged in transactional sex with males who take advantage of their need for money in order to obtain basics like sanitary towels. Teenage pregnancies, among other risk factors, are adding to the number of girls who are not in school. Even before Covid 19, there were 98 million teenage girls worldwide who were not in school and research suggests the pandemic could have added an additional (UDHS, 2022).

Teenage pregnancy and motherhood are major issues facing most developing countries (WHO, 2024b). Because of the adverse impacts on girl children, policy makers, social workers, and other human resource providers are concerned about this issue in both first- and third-world nations, including the United States (WHO, 2024b). Due to the continuous increasing numbers of teenage pregnancies, there is need to find more information regarding this problem (increased teenage pregnancy) and to create awareness among the teenagers in Uganda concerning the causes and the effects of these teenage pregnancies and what can be done to reduce the increasing numbers, and for the best of our knowledge and literature search done there is no study about teenage pregnancy has been done in Iganga District separately.

### **1.3 Problem statement**

Teenage pregnancy is a serious public health and social problem, with 95% occurring in developing countries including Uganda. According to World Health Organization (WHO) most of the teenage pregnancies and child birth are not planned and wanted, although a few are planned and wanted (WHO, 2024b). Uganda has one of the highest rates of teenage pregnancies in sub-Saharan Africa, estimated at about 25% (UBOS, 2022). Teenage pregnancy has a high effect on the lives of girls in healthy, education and socially. Sadly, teenage pregnancies contribute to 20% of infant deaths and 28% of maternal deaths. This poses a significant burden on the healthcare system. Despite numerous attempts and interventions, it is still crucial to comprehend on the prevalence of teenage pregnancy and its associated factors among girls seeking care at Iganga General Hospital in order to come up with effective intervention strategies to address the root causes and mitigate the long-term consequences for both the young mothers and their children. The COVID-19 pandemic exacerbated the challenges faced by teenage mothers in Uganda, including limited access to healthcare services, economic hardships, and disruptions to education. The pandemic also highlighted existing inequalities and vulnerabilities among this population, further underscoring the need for targeted interventions to support their well-being. Therefore, understanding the impact of the pandemic on teenage pregnancy rates and associated factors among girls seeking care at Iganga General Hospital is crucial for developing effective strategies to address their unique needs in the post-COVID-19 era. By examining the prevalence of teenage pregnancy and its associated factors in this context, this research aims to inform evidence-based interventions that can promote the health and social outcomes of young mothers and their children in Uganda, specifically Iganga District and identify methods to improve their well-being.

## **1.4 Justification**

Since 2015, the Ministry of Education and Sports (MoES), in collaboration with the Ministry of Health, had implemented guidelines to manage and prevent HIV/AIDS and unplanned pregnancies within Ugandan schools (MoES, 2019). Despite Uganda's supportive legislative framework promoting gender equality in education, available data painted a concerning picture. Teenage pregnancy rates among girls aged 10-19 enrolled in educational institutions had been rising (MoES, 2019). This trend had the potential to contribute to the high rate of early school dropout in the country. The COVID-19 pandemic was expected to further intensify this problem. While the guidelines affirmed the right to education for pregnant or parenting students, limitations on readmission existed. The guidelines prioritized readmission for pregnant girls and women, offering recourse for parents and students facing rejection from public schools. Previous research had explored the causes of teenage pregnancy among young girls (MoES, 2019). However, a critical knowledge gap remained regarding the current prevalence and contributing factors in the post-COVID-19 era, which had unfortunately witnessed a significant increase in teenage pregnancies. This study aimed to bridge this knowledge gap by contributing to the existing body of research on teenage pregnancy in Uganda and providing valuable insights. It was anticipated that the study would pave the way for further research, open discussions, and collaborative efforts to address the challenges associated with teenage pregnancy in Uganda.

## **1.5 Significance of the Study**

Any research study should aim to advance both the subject matter under investigation and society as a whole. It was hoped that the study's findings would offer empirical data to guide the development of policies and programs to help pregnant girls and decrease the number of teenage pregnancies. The study aimed to provide knowledge about the factors that led to teenage pregnancies in girls, which could help educate and assist in reproductive health. This was essential to meet the requirements of this vulnerable group in terms of reproductive health. The study also looked at the types of help offered to pregnant girls during antenatal care, providing information on the social and community support networks already in place. The knowledge provided could be used to strengthen these support networks and reduce the social stigma associated with teenage pregnancy.

By identifying the unique needs and vulnerabilities of this population, the research aimed to inform targeted interventions and policies to address pandemic-related impacts on teenage pregnancy rates and support the reproductive health and overall well-being of pregnant girls. Understanding the available support and resources during antenatal care was expected to strengthen social and community networks that assisted this vulnerable group. Addressing social stigma was anticipated to help reduce barriers to care and promote a more supportive environment for pregnant teenagers post-COVID-19. Ultimately, the study aimed to advance knowledge and improve outcomes for pregnant girls in Uganda, particularly in the wake of the COVID-19 pandemic.

## **1.7 Research objectives**

### **1.7.1 General objective**

To assess the prevalence of teenage pregnancy and its associated factors among girls seeking care from Iganga General Hospital Iganga District.

### **1.7.2 Specific objectives**

- I. To determine the prevalence of teenage pregnancy among girls seeking care from Iganga

General Hospital Iganga District.

- II. To assess factors associated with teenage pregnancy among girls seeking care from Iganga  
General Hospital in Iganga District.

### **1.7.3 Research questions**

- i. What is the prevalence of teenage pregnancy among girls seeking care from Iganga

General

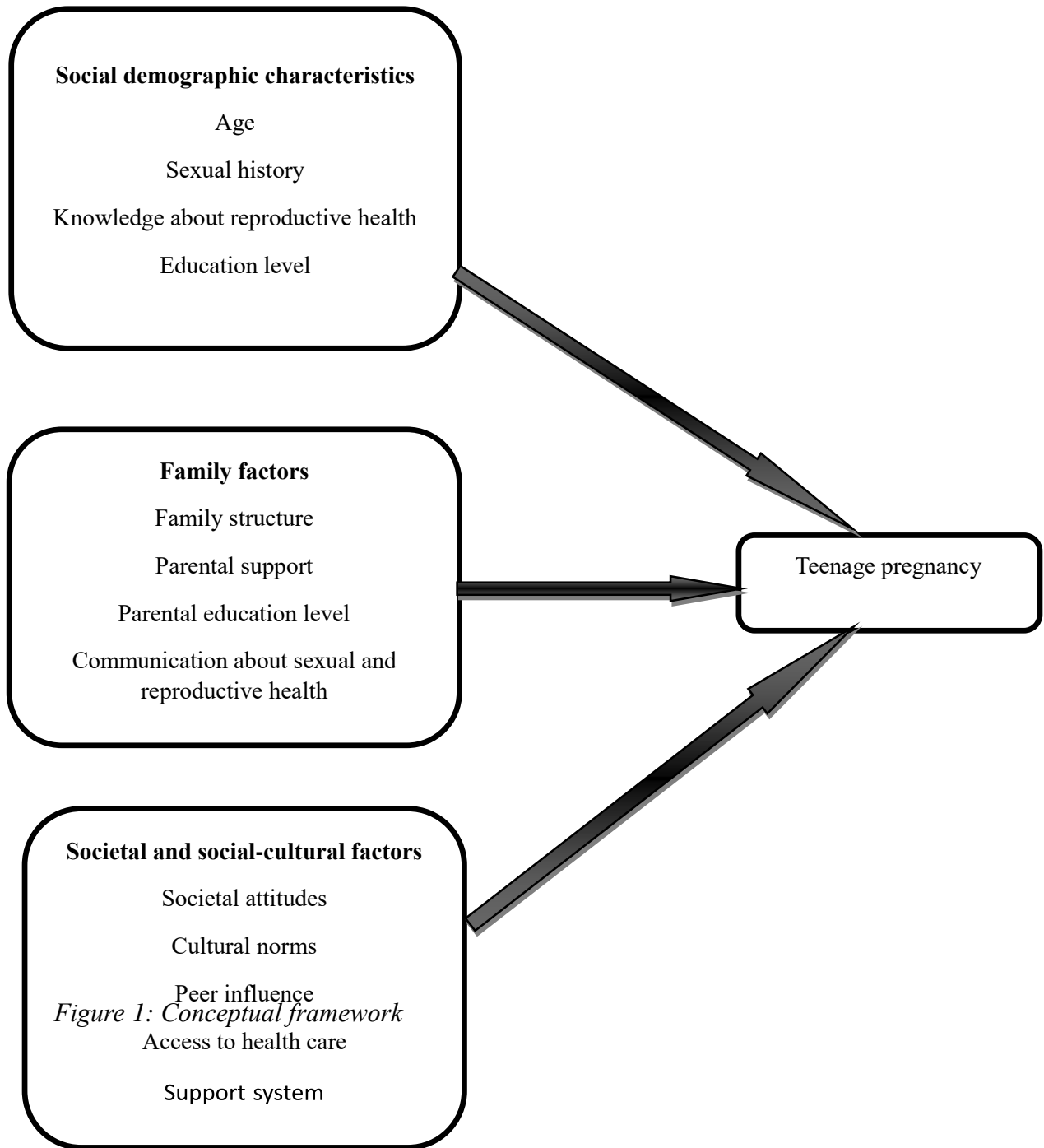
Hospital Iganga District?

- ii. What are the factors associated with teenage pregnancy among girls seeking care from

Iganga General Hospital Iganga District.

Independent variables

Dependent variables



*Figure 1: Conceptual framework*

*Figure 1: A conceptual framework*

## **1.8 Narration of the Conceptual Framework**

Teenage pregnancy remains a significant public health concern, particularly in low- and middle-income countries, where it contributes to maternal morbidity, school dropout, and intergenerational cycles of poverty. This conceptual framework was informed by literature review studies that outlines how teenage pregnancy is influenced by an interplay of social-demographic characteristics, family factors, and socio-cultural dynamics.

### **Social demographic characteristics**

Key demographic factors such as age, sexual history, education level, and knowledge about reproductive health significantly influence the likelihood of teenage pregnancy. Adolescents with limited knowledge about reproductive health are more likely to engage in unprotected sex, increasing their risk of pregnancy (Chandra-Mouli et al., 2015). Early sexual initiation and lower levels of education are associated with higher rates of teenage pregnancy (Yakubu & Salisu, 2018), as education is known to delay marriage and childbirth through improved knowledge and access to opportunities.

**Family factors:** The family structure and parental involvement play crucial roles in shaping adolescents' sexual behavior. Teens from single-parent families or those lacking parental support are at greater risk of early pregnancy due to reduced supervision and guidance (Gloria, 2017; Jacobs, 2019). Moreover, parental education level is a critical determinant, as educated parents are more likely to discuss sexual and reproductive health with their children, fostering informed decision-making (Challa et al., 2018; Okigbo et al., 2015). Open communication within families has been linked to delayed sexual debut and increased use of contraception among adolescents.

Societal and socio-cultural factors: Societal attitudes, cultural norms, peer influence, and access to healthcare also contribute to teenage pregnancy. In many communities, prevailing cultural norms may promote early marriage and discourage contraceptive use, increasing pregnancy risks (Alukagberie et al., 2023; Bukuluki et al., 2021). Peer pressure is another potent factor; adolescents often emulate the behaviours of their peers, which can lead to early and risky sexual activity (Fearon et al., 2015; Sifer & Getachew, 2024; Widman et al., 2016). Limited access to youth-friendly reproductive health services and weak support systems further exacerbate the situation (Nartey et al., 2025; Ninsiima et al., 2021).

Therefore, teenage pregnancy is a multifactor issue influenced by interaction demographic, familial, and cultural variables. Addressing it requires comprehensive strategies that involve families, communities, and health systems to equip adolescents with the knowledge, skills, and support necessary to make informed reproductive choices.

### **1.9 Scope of the Study**

This study comprehended factors associated with teenage pregnancy, including living in rural areas, not attending school, early marriage, lack of communication between parents and teenagers about sexual and reproductive health (SRH) issues, the educational level of the teenagers, and family history of teenage pregnancy. In order to understand the specific reasons influencing these phenomena, the study also examined the social, cultural, and economic causes of teenage pregnancy in the Ugandan setting.

## **CHAPTER TWO**

### **2.1 Literature Review**

This section comprised a summary of the theory and existing information about the prevalence, causes, and effects of teenage pregnancy among girls. A search for empirical literature using electronic databases, articles, journals, and textbooks had been done.

### **2.2 Empirical Literature Review**

This subsection highlighted several research studies conducted by different scholars that were relevant to the objectives of the current research.

### **2.3 Prevalence of Teenage Pregnancy**

According to Kichengast (2016), in developed countries, teenage birth rates were quite low, and teenage motherhood was debated as a public health problem and considered a societal challenge. However, there were considerable differences in teenage pregnancy rates between different developed nations. The majority of teenage mothers (60%) were accounted for by the United States, which had a teenage birth rate about four times that of the European Union (EU) average.

Within the European Union, the highest teenage birth rates were found in the UK (27%) and new EU members such as Bulgaria (33%), Romania (34%), and the Baltic states (21-23%). In contrast, Switzerland (4%), the Netherlands (5%), Sweden (6%), Japan, and Korea (less than 5%), Italy, Spain, Denmark, Finland, France, Luxembourg, Belgium, Greece, Norway, Germany, and Austria (less than 15%) all had extremely low rates of teenage births (Kirchengast, 2016).

Smith et al. employed a cross-sectional study to determine the prevalence of teenage pregnancy in developed nations, found that the prevalence ranged from 2% to 6%, with an average of 4%. The sample size of this study was 10,000 teenagers from various developed countries (Smith et al., 2018).

A community-based cross-sectional study conducted by Kassa, Belay, and Ayele (2021) among 343 teenagers found a prevalence of 25.4% for teenage pregnancy (Kassa et al., 2021). This differed from Nagandla and Kumar (2020), who conducted a retrospective hospital-based case-control study in Malaysia and found a teenage pregnancy prevalence of 2.8% among a control group of 169 pregnant teenagers (Nagandla & Kumar, 2020). The differences between the studies were in design and sample size, with Kassa et al. using a community-based cross-sectional study and a larger sample size compared to Nagandla and Kumar, who used a hospital-based case-control study.

The World Health Organization (WHO, 2024b) reported that 95% of teenage pregnancies and childbirths occurred in underdeveloped nations, making teenage pregnancy a critical public health and social problem. The majority of teenage pregnancies and childbirths were unplanned. Uganda had one of the highest rates of teenage pregnancies in sub-Saharan Africa, estimated at 25%. In Lira District, northern Uganda, the rate was the highest (UBOS, 2022). Despite socio-cultural and religious norms promoting abstinence until marriage, double standards concerning sexuality existed, where girls were expected to be modest and passive, while boys were encouraged to assert their masculinity (WHO, 2024b). The teenage pregnancy rate of 25% in Uganda, though concerning, was lower than that in other sub-Saharan countries.

A cross-sectional study on adolescent pregnancy in Uganda, using a sample size of 1,000 teenage girls, and found a prevalence of 25% (Nuwabaine et al., 2023).

Chemutai et al. conducted a cross-sectional study at Mbale Regional Referral Hospital and found a teenage pregnancy prevalence of 20.6% (Chemutai et al., 2022), while Mezmur et al. conducted a community-based study in Ethiopia and found a prevalence of 30.2% (H. Mezmur et al., 2021). The differences between these studies were in the study design, with Chemutai et al. using a cross-sectional design and Mezmur et al. using a community-based study.

The Uganda Demographic Health Survey (UBOS, 2022) reported that 23% of girls between the ages of 15 and 19 were either pregnant or had already had a child. This issue was particularly concerning in the Busoga region of Eastern Uganda, where the teenage pregnancy rate was 27% in rural areas, compared to 19% in urban Uganda.

## **2.4 Factors Associated with Teenage Pregnancy**

Literature shows that in different settings, the reported teenage pregnancy was caused by a variety of factors, including individual behavior, traditional and sociocultural norms, and religious beliefs. In marginalized areas, teenage pregnancies were typically caused by poverty and a lack of access to education and employment opportunities.

### **2.4.1 Low Education Attainment**

A cross-sectional study conducted in the rural area of Ethiopia focusing on adolescents aged 15-19 years, a study of 1,200 respondents as part of the study to find out how common adolescent pregnancy is and what factors influence it and found that teenagers living in rural areas were four times more likely to become pregnant compared to students in urban areas (Ayanaw Habitu et al., 2018). This was consistent with research conducted in South Asia which analyzed data from different research were using a systematic review design (Poudel et al., 2022). Focusing on teenagers between the ages of 10 and 19, the review highlighted inequalities in educational

access and connected to low educational attainment to adolescent pregnancy in several South Asian areas (Poudel et al., 2022).

#### **2.4.2 Lack of Access to Contraceptives**

A cross-sectional study by Tumwizera et al., reported that non-users of contraception were almost eleven times more likely to become pregnant than users (Tumwizere et al., 2024). Additionally, a study by Mohammed et al. demonstrated that adolescents in rural areas had limited access to contraceptive services, contributing to higher pregnancy rates (Mohammed et al., 2024).

#### **2.4.3 Parental Income**

Results from a cross-sectional study found that teens who became pregnant often came from low-income families and lacked the resources necessary to raise their children. Low socioeconomic status also contributed to a lack of family connectedness, which increased the risk of teenage pregnancy (Crooks et al., 2022). Similarly, a cross-study among adolescents revealed that adolescents from families with lower income levels were more likely to experience teenage pregnancy due to limited educational opportunities (Moshi & Tilisho, 2023).

#### **2.4.4 Cultures, Customs, and Traditions**

Results from a cross-sectional found that certain cultures, customs, and traditions encouraged early or teenage marriage, which led to early pregnancies in these settings. For instance, the Maasai people in Kenya and Tanzania view early marriage as a rite of passage for girls, tying their value to their marital status and ability to bear children (Ochen et al., 2019a). This cultural practice not only increases the likelihood of early pregnancies but also frequently restricts girls' access to education and personal development opportunities. Similarly, child marriage is common in parts of South Asia, especially in rural areas of India and Bangladesh, due to longstanding traditions that favor marrying girls at a young age to secure family alliances and

maintain social status. Cultural practices like "dowry" serve to further perpetuate these cultural norms

Additionally, a study conducted among participants in the rural communities in Nigeria also highlighted that cultural norms in specific communities often prioritize early marriage, further exacerbating the issue of teenage pregnancy (Ochen et al., 2019a).

#### **2.4.5 Sexual Violence**

A cross-sectional study reported that teenage pregnancies increased when girls were denied the freedom to make decisions about their sexual and reproductive health (Iqbal et al., 2017). Furthermore, a study by carried a cross-sectional study on adolescents found those experiences of sexual violence significantly increased the likelihood of adolescent pregnancies among young girl (Ajayi & Ezegbe, 2020).

#### **2.4.6 Pornography and Negligence**

UNFPA,2021 linked teenage pregnancy to pornography and parental negligence, with 48% of teenage mothers dropping out of school due to complications from their pregnancies (UNPFA, 2021). Furthermore, a study by Smith et al. (2020) who did a cross-sectional study on teenagers in various in the Thailand Bangkok indicated that exposure to pornography was associated with increased risky sexual behavior among adolescents (Thepthien & Celyn, 2022).

#### **2.4.7 Drugs and Alcohol Use**

According to a study conducted elsewhere, teenagers in who use drugs or alcohol are much more likely to engage in dangerous sexual practices (Ajisuksmo, 2021; Theuri & Mutisya, 2021). The researchers used a cross-sectional study design to poll teenagers between the ages of 14 and 19 to find out how they use drugs and how they perceive the hazards of sexual activity. In order

to lower the prevalence of unwanted pregnancies and STDs in this population, the results showed that substance users were more likely to have multiple sexual partners and engage in unprotected sex. This emphasizes the need for integrated interventions that address substance use and sexual health education. Additionally, a study by Thompson et al. (2021) who carried out a longitudinal study on 1500 adolescents in California found that substance use among adolescents was a significant predictor of early pregnancy.

#### **2.4.8 Sexual Abuse**

Early sexual abuse had also been connected to subsequent teenage pregnancies, with child sexual abuse increasing the likelihood of unplanned pregnancies (Noll et al., 2009; Richner, 2021). Furthermore, a matched cohort study conducted among a total of 661 girls (aged 13–18 years) with a corroborated by Child Protection Services CSA report between 2001 and 2010 were matched to 661 girls from the general population upon age, biological sex, urban Child Protection Services area, and public drug insurance admissibility at reporting date (Fortin-Langelier et al., 2019). Results indicate that compared with participants from the general population, those with a history of CSA were 4.6 times more likely to consult for at least one pregnancy, 5.3 times more likely to consult for at least one complication during pregnancy or delivery, and on average 5.2 and 3.3 times more likely to consult for at least one live birth and provoked abortion, respectively. There were too few observations to compare fatal losses between groups (Fortin-Langelier et al., 2019).

#### **2.4.9 Rebellion**

It is reported that some teenagers chose to become pregnant as a way of asserting their independence and control over their lives (Mollborn, 2017; Robertson, 2021). Additionally, a study by Lewis et al. (2018) who carried out a qualitative study on a 30 adolescents in south Africa

revealed there was frequently a correlation between higher rates of teenage pregnancy and rebellious conduct among adolescents.

#### **2.4.10 Peer Pressure**

In a community-based qualitative study was conducted from March to May 2023. Two focus group discussions were conducted with community health volunteers and the mothers of teenage girls. Semi-structured interviews were conducted on the case histories of 19 teenage mothers and 18 key informants. It was found out that four major reasons emerged for unintended teenage pregnancies: (1) lack of knowledge or awareness about the human reproductive system, (2) lack of knowledge about family planning (FP), (3) financial challenges, and (4) low access to FP. At the study site, cultural norms and stereotypes, such as “infertility caused by FP,” “freedom of sex by promoting FP,” and “cultural taboos on having sex before marriage and talking about sexuality,” were observed as barriers in promoting FP to teenagers (Harada et al., 2024).

## **CHAPTER THREE**

### **3.0 Methods**

This chapter described the materials, procedures, and methods used in this research study and how all activities were carried out.

### **3.1 Study Design**

The study was a cross-sectional, Analytical, Quantitative study involving the collection of quantitative data, which was utilized to analyze the information collected from the target population of pregnant teenage girls. The study focused on measuring the prevalence of teenage pregnancy among different age groups, education statuses, pregnancy orders, and marital statuses of the girls. Questionnaires were administered to gather quantitative data on the prevalence and factors associated with teenage pregnancy. Statistical analysis was employed to analyze the data and draw conclusions about the relationships between variables.

The research questions focused on the quantitative aspects of the study, such as the prevalence of teenage pregnancy and the factors contributing to teenage pregnancy. The data collected was analyzed using statistical methods to provide a comprehensive understanding of the issue of teenage pregnancy.

### **3.2 Study Setting**

Iganga General Hospital, located in Iganga District, served as the study site. The hospital is approximately 34.5 kilometers (21 miles) west of Jinja Regional Referral Hospital and approximately 50 kilometers (31 miles) east of Mulago National Referral Hospital. The hospital coordinates were: 0°22'05.0"N, 32°56'44.0"E (Latitude: 0.368050; Longitude: 32.945553). The

hospital had a bed capacity of 200, (2024,) it admitted 11,699 patients and delivered 3,784 babies. The hospital served Iganga District and parts of Kayunga District and Buvuma District.

### **3.3 Populations**

To ensure the effectiveness of the study, a systematic approach was implemented for respondent recruitment:

**Recruitment Method:** The principal investigator collaborated with the District Health Officer and engaged research assistants to facilitate the recruitment process. With permission granted, they approached teenage girls seeking care at Iganga General Hospital, specifically targeting those aged 13 to 19 years who were either pregnant or vulnerable to pregnancy.

**Informed Consent:** Prior to participation, the researcher ensured that potential respondents understood the goals of the study. In cases where respondents could not legally consent on their own, assent was obtained in the presence of their guardians, who also provided their consent. This process allowed for an ethical recruitment of participants while respecting the rights of minors.

**Sample Selection:** The nursing staff at the triage helped identify eligible teenage girls by separating those within the desired age range of 13 to 19 years. This structured approach to recruitment ensured that participants represented the target population effectively.

#### **3.3.1 Target population**

The study population comprised of teenage girls aged between 13 to 19 years seeking care at Iganga general hospital.

### **3.3.2 Accessible population**

All teenage girls seeking care at Iganga general hospital during the time of study

### **3.3.3 Study population**

All teenage girls seeking care at Iganga general hospital during the study period and had either consented or assented to participate into the study.

## **3.4 Eligibility Criteria**

### **3.4.1 Inclusion Criteria**

All teenage girls seeking care at Iganga General Hospital during the study period who consented or assented to participate were included in the study.

### **3.4.2 Exclusion Criteria**

Teenage girls with mental health conditions were explicitly excluded from participation in the study to ensure the safety and wellbeing of all respondents, maintaining the integrity of the research findings.

## **3.5. Sample size**

The sample size was calculated using the Kish & Leslie (Kish, 1965) formula for estimating proportions.

$$\text{Sample size } n = \frac{z_{1-\alpha}^2 p(1-p)}{d^2}$$

Where;  $n$  = calculated sample size,

$Z_{(1-\alpha)}$  is standard normal value corresponding to 95% level of confidence=1.96, P is assumed prevalence of teenage pregnancy= 25.4% (Kassa et al., 2021) d is desired absolute error = 5%  $n = [(1.96^2 * 0.254 * (1 - 0.254))] / (0.05^2)$   
= 291.169

=292 This was the sample size which was used for this study. However, we did not account for non-response since we used an interviewer administered questionnaires and we collected data until the sample size was achieved

### **3.6 Sampling procedures**

### **3.7 Study Variables**

Consecutive sampling was employed in the study. The project began with the principal investigator obtaining administrative permission from the District Health Officer. The researcher, along with research assistants and under the guidance of a senior nursing officer, approached the teenage girls at the hospital. Those willing to participate were informed about the study and provided consent or assent. The nursing staff was instrumental in identifying eligible teenage girls, ensuring a streamlined recruitment process.

#### **3.7.1 Independent Variables**

Demographic characteristics: age, marital status, religion, residence, ethnicity, education level.

Economic characteristics: social-economic status, financial support, income level, and employment history (if any).

Other characteristics: access to sex education, parental involvement, and peer influence.

### **3.7.2 Dependent Variables**

Teenage pregnancy: Teenage pregnancy was defined as pregnancy in a female teenager between the ages of 13 to 19 years.

### **3.8 Data Collections**

Data was collected using an adopted questionnaire issued to the participants after consenting/assenting to participate in the study. The participants were accessed at the Iganga General Hospital in August 2024. The participants had their ages already written in their hospital book this helped us track their ages before filling out the questionnaires. The questionnaire was pilot-tested on 10-teenagers who were met at Iganga general hospital before starting data collection process but before the main study to inform and modify the data collection process. The study team received one day of training on the protocol, data collection tools, and procedures before the commencement of data collection.

### **3.9 Data Management**

The completed questionnaire forms with gathered data were entered into Epi-data software. Standardized entry procedures such as double-entry systems or verification methods were used to minimize errors. The entered data was categorized and coded to facilitate further analysis, including coding responses to open-ended questions. Data quality was ensured through data cleaning procedures, checking for outliers or missing data. All data was stored securely on computers and external drives, anonymized, and accessed only by the principal investigator using secure systems and passwords.

### **3.10 Data Analysis**

#### **3.10.1 Univariate Analysis**

Data from Epi-data software was exported to STATA 15 for analysis. Numerical variables were summarized using the mean and standard deviation if normally distributed or median and interquartile range if not normally distributed. Categorical variables were summarized using proportions.

#### **3.10.2 Bivariate Analysis**

Bivariate analysis was used to select variables for multivariate analysis. Since the prevalence of the outcome variable (teenage pregnancy) was >10%, modified Poisson regression was used to assess the association of each independent variable with the dependent variable. Variables with a p-value of less than 0.2 were selected for the multivariate analysis model. A p-value of 0.2 was used to reduce false negatives, by using a more lenient p-value cutoff (0.2) helps reduce the risk of false negatives, where potentially important variables are incorrectly excluded in the further analysis. Prevalence ratios were reported as measures of association between the outcome and associated factors.

#### **3.10.3 Multivariate Analysis**

Selected variables from the bivariate analysis were assessed for interaction in the multivariate model. Interaction terms were formed using only significant variables (p-value 0.05). A chunk test was used to assess interaction, comparing the reduced model (with basic variables) and the full model (with basic variables and interaction terms). Confounding was assessed by comparing the crude and adjusted models, with a 10% or greater change in the measure of association indicating confounding. The final model was checked for goodness of fit.

### **3.11 Ethical Considerations**

Teenagers voluntarily participated in the study, with the right to discontinue at any time.

In certain situations, with minors or individuals with limited capacity, assent was obtained from the parents/ guardians. Confidentiality was maintained by assigning participant registration numbers instead of names. Personal identification information was not reported, and all hard copy documents were securely stored. Permission to conduct the study was obtained from the administration of Iganga General Hospital, and ethical approval was granted by the Research Ethics Committee of UCU.

### **3.12 Quality Control**

The study team was trained on the study protocol and data collection tools to ensure consistency. The questionnaires were pilot-tested among 10 selected teenagers who were found at the hospital before the final data collection process, and necessary changes were made before. Completeness of the questionnaires was ensured to avoid missing data that could interfere with the analysis.

Double data entry was performed to enhance data quality. Data was anonymized and securely stored on systems accessible only by the principal investigator.

### **3.13 Dissemination**

A report of the findings will be made available to Uganda Christian University Library and Iganga General Hospital. The research findings will be published in a peer-reviewed journal, and the findings will help to inform policy on teenage pregnancy and prevention strategies among girls.

## CHAPTER FOUR

### 4.0 Results

#### 4.1 Social demographic characteristics

The mean age and the standard deviation, mean (SD) of the participants was 18.2(1.37) years.

Majority of the participants were aged 18-19 years (n=236, 80.8%). Majority of them were from Busoga 66.9%(n=195), reported to be married/cohabiting (57.2%, n=167). Almost half of the respondents were Christians 49.7%(n=145) with most of them having attained primary level of education 44.5%(n=130). However, most of the respondents reported to have no employment 76.7%(n=224) (Table 1)

*Table 1. The social demographic characteristics of the 292 Teenage girls seeking care at Iganga general Hospital.*

Variable	Category	Mean (SD)	Frequency n, (%)
Age of the respondents	13-14		10(3.4)
	15-17		46(15.8)
	18-19	18.2(1.37)	236(80.8)
Tribe of the respondents	Alur		2(0.7)
	Bakiga		7(2.4)
	Banyoro		7(2.4)
	Batooro		9(3.1)
	Banyankole		12(4.1)

	Baganda	40(13.7)
	Busoga	195(66.9)
	Others	20(6.9)
Marital status		
	Married/cohabiting	167(57.2)
	Single	125(42.8)
Religion of the respondents		
	Christians	145(49.7)
	Moslems	134(45.9)
	Others	13(4.5)
Level of education		
	No formal level	31(10.6)
	Primary level	130(44.5)
	Secondary level	105(36.0)
	Tertiary level	26(8.9)
Employment status		
	No employment	224(76.7)
	Employed	68(23.3)

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#### **4.2 Sexual behaviors of the study participants**

Most respondents had their first sexual intercourse between ages 15-17 years (54.1%, n=158) and reported having more than one sexual partner (71.9%, n=210). A majority had never used contraceptives (66.1%, n=193) and lacked knowledge about them (53.1%, n=155). Additionally,

most respondents were unaware of the risks associated with teenage pregnancy (61.6%, n=180) and did not understand prenatal care (59.6%, n=174) (Table 2).

*Table 2. Sexual behaviors of 292 Teenage girls seeking care at Iganga general Hospital*

<b>Variable</b>	<b>Category</b>	<b>Frequency n, (%)</b>
Age at first sexual intercourse	<15 yrs	46(15.8)
	15-17yrs	158(54.1)
	>17 yrs	88(30.1)
Number of sexual partners	Only 1	82(28.1)
	More than 1	210(71.9)
Ever used contraceptives	No	193(66.1)
	Yes	99(33.9)
Knowledge about contraceptives	No	155(53.1)
	Yes	137(46.9)

### **4.3 Family status and support of the participants**

Most respondents come from extended families (55.8%, n=163). The majority have low family income levels (89.4%, n=261) and receive support from their families (59.3%, n=173). In terms of time spent with parents, a moderate amount is most common (48.0%, n=140). Regarding

parental education, the highest proportion of parents attained formal education (80.8%, n=236) (Table 3).

*Table 3. Family status and support of 292 Teenage girls seeking care at Iganga general Hospital*

<b>Variable</b>	<b>Category</b>	<b>Frequency n, (%)</b>
Family structure	Extended family	163(55.8)
	Nuclear family	129(44.2)
Perceived Family income level	High	31(10.6)
	Low	261(89.4)
Any support from family	Yes	173(59.3)
	No	119(40.8)
Perceived time spent with parents	Adequate	170(58.2)
	Not adequate	122(41.8)
Parental level of education	Formal education	236(80.8)
	No formal education	56(19.2)

#### **4.4 Cultural and societal factors**

Majority believe culture contributes to teenage pregnancy (57.5%, n=168) and that cultural taboos around sex in teenagers are prevalent (59.6%, n= 174). Most respondents reported no

pressure from peers regarding intercourse (57.2%, n=167) and over half noted barriers to access (55.5%, n=162), and a majority indicated that reproductive health services are not well provided in their communities (64.4%, n=188) (Table 4)

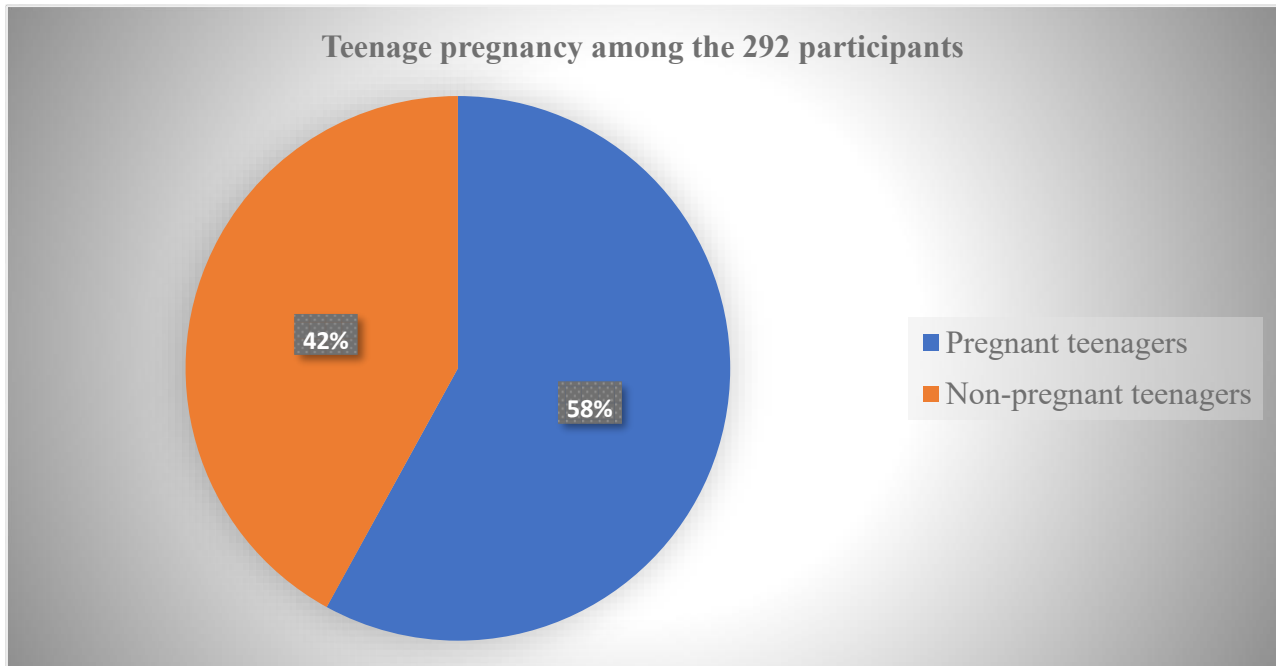
*Table 4. Cultural and societal factors of 292 Teenage girls seeking care at Iganga general Hospital*

<b>Variable</b>	<b>Category</b>	<b>Frequency n, (%)</b>
<b>Perceived Cultural contribution to TP*</b>		
	Yes	168(57.5)
	No	124(42.5)
<b>Perceived Cultural taboos about sex in teenagers</b>		
	Yes	174(59.6)
	No	118(40.4)
<b>Perceived Pressure from peers</b>		
	No	167(57.2)
	Yes	125(42.8)
<b>Access to reproductive health</b>		
	Yes	185(63.4)
	No	107(36.6)
<b>Barriers to access of reproductive health</b>		
	Yes	162(55.5)
	No	130(44.5)

*TP\*-Teenage pregnancy*

#### 4.5 Prevalence of teenage pregnancy

The prevalence of teenage pregnancy among the 292 Teenage girls seeking care at Iganga general hospital was 57.5% (n=168: 95%-CI: 51.64-63.27) as shown (Figure 2).



*Figure 2: The distribution teenage pregnancy among the 292 participants*

## 4.6 Factors associated teenage pregnancy among 292 Adolescent seeking care at Iganga general hospital

### 4.6.1 Bivariate analysis of social demographics and sexual behaviors related to teenage pregnancy among the 292 Teenage girls seeking care at Iganga general hospital

At bivariate analysis, variables marital status, employment status of the respondent, age at first sexual intercourses, perceived knowledge about contraceptives and contraceptive use were taken to multivariate analysis since they had a p-value<0.2 (Table 5).

*Table 5. Bivariate analysis of social demographics and sexual behaviours related to teenage pregnancy among the 292 Teenage girls Seeking care at Iganga general hospital*

Variable	Teenage pregnancy		PR	95%-CI	P-value
	Yes n, (%)	No n, (%)			
Age of the respondents					
13-14	10(100.0)	0(0.0)	Ref		
15-17	45(97.8)	1(2.2)	1.11	0.887-1.478	0.655
18-19	144(61.0)	92(39.0)	1.22	0.983-1.505	0.712
Marital status					
Married/cohabiting	81(48.5)	86(51.5)	Ref		
Single	87(69.6)	38(30.4)	1.43	1.181-1.744	<0.001
Religion of the respondent					
Christian	86(59.3)	59(40.7)	Ref		
Moslem	74(55.2)	60(44.8)	0.93	0.759-1.142	0.493
Others	8(61.5)	5(38.5)	1.04	0.661-1.629	0.873
Level of education of the participant					
Formal education	151(57.9)	110(42.1)	Ref		

No formal education	17(54.8)	14(45.2)	1.05	0.753-1.477	0.775
Employment status of the respondent					
Employed	27(39.7)	41(60.3)	Ref		
No employment	141(63)	83(37)	1.59	1.163-2.162	<b>0.004</b>
Age at first sexual intercourse					
<15 yrs	34(73.9)	12(26.1)	Ref		
15-17yrs	96(60.8)	62(39.2)	0.82	0.664-1.017	<b>0.071</b>
>17 yrs	38(43.2)	50(56.8)	0.58	0.435-0.784	<b>&lt;0.001</b>
Number of sexual partners					
Only 1	51(62.2)	31(37.8)	Ref		
More than 1	117(55.7)	93(44.3)	1.12	0.907-1.374	0.299
<hr/>					
Perceived Knowledge about contraceptives					
Yes	64(46.7)	73(53.3)	Ref		
No	104(67.1)	51(32.9)	1.44	1.164-1.773	<b>0.001</b>
Ever used contraceptives					
Yes	48(48.5)	51(51.5)	Ref		
No	120(62.2)	73(37.8)	1.28	1.018-1.616	<b>0.035</b>
<hr/>					

#### **4.6.2 Bivariate analysis of family, cultural and societal factors related to teenage pregnancy among the 292 Teenage girls Seeking care at Iganga general hospital**

At bivariate analysis, variable access to reproductive health was taken for multivariate analysis since it had a p-value <0.02 (Table 6).

*Table 6. Bivariate analysis of family, cultural and societal factors related to teenage pregnancy among the 292 Teenage girls seeking care at Iganga general hospital*

Variable	Teenage pregnancy		PR	95%-CI	P-value
	Yes n, (%)	No n, (%)			
Family structure					
Nuclear family	68(52.7)	61(47.3)	Ref		
Extended family	100(61.4)	63(38.6)	1.16	0.949-1.428	0.245
Perceived Family income level					
High	15(48.4)	16(51.6)	Ref		
Low	153(58.6)	108(41.4)	1.21	0.830-1.768	0.32
Perceived time spent with parents					
Adequate	90(52.9)	80(47.1)	Ref		
Not adequate	78(63.9)	44(36.1)	1.21	0.994-1.467	0.58
Parental level of education					
Formal education	136(57.6)	100(42.4)	Ref		
No formal education	32(57.1)	24(42.9)	1.01	0.784-1.298	0.948
Perceived cultural contribution to TP					
No	75(60.5)	49(39.5)	Ref		
Yes	93(55.4)	75(44.6)	0.92	0.752-1.116	0.378
Perceived Pressure from peers					
No	91(54.5)	76(45.5)	Ref		
Yes	77(61.6)	48(38.4)	1.13	0.929-1.376	0.221

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Access to reproductive health					
Yes	98(53.0)	87(47.0)	Ref		
No	70(65.4)	37(34.6)	1.23	1.017-1.499	<b>0.033</b>
Perceived Barriers to access of reproductive health					
No	78(60.0)	52(40.0)	Ref		
Yes	90(55.6)	72(44.4)	1.52	0.684-2.254	0.619

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#### **4.6.3 Multivariate analysis for the factors associated with teenage pregnancy**

At multivariate analysis, Perceived knowledge on contraceptives, Employment status of participant and Age at first sexual intercourse were significantly associated with teenage pregnancy since they had p-value <0.05 (Table 7)

Table 7: Multivariate analysis for the factors associated with teenage pregnancy among the 292

Teenage girls seeking care at Iganga general hospital

Variable	Category	cPR	aPR(95%-CI)	P-value
<b>Marital status</b>				
	Married	Reference		
	Single	1.43	1.25(0.921-1.523)	0.065
<b>Perceived knowledge on contraceptives</b>				
	Yes	Reference		
	No	1.44	1.28(1.039-1.580)	<b>0.02</b>
<b>Employment status of participant</b>				
	Employed	Reference		
	None	1.59	1.37(1.008-1.858)	<b>0.044</b>
<b>Age at first sexual intercourse</b>				
	<15yrs	Reference		
	15-17yrs	0.82	0.80(0.702-1.035)	0.107
	>17yrs	0.58	0.65(0.492-0.863)	<b>0.003</b>
<b>Access to reproductive services</b>				
	Yes	Reference		
	No	1.23	1.19(0.985-1.436)	0.071

## CHAPTER FIVE

### 5.1 DISCUSSION

The primary aim of this study was to assess the prevalence of teenage pregnancy and its associated factors among teenage girls seeking care at Iganga General Hospital in Iganga District. The findings disclosed a prevalence rate of 58%, indicating that nearly 6 in 10 pregnant teenage girls attending care at this facility are under the age of 19 years. These findings do not concur with other studies for instance, a cross-sectional study conducted by (Haymanot Mezmur et al., 2021) in Eastern Ethiopia reported a significantly lower prevalence of 30.2% (95% CI: 28.3-32.1). This difference can be explained by differences in study design: (Haymanot Mezmur et al., 2021) research was community-based, which represents a broader population, whereas our study was hospital-based and reflects a more specific group of girls in a more rural setting seeking antenatal care. Additionally, the sample size in (Haymanot Mezmur et al., 2021)'s study was substantially larger, with 2258 female teenagers participating compared to just 292 in our study. This study assessed the prevalence of teenage pregnancy among girls seeking care at Iganga Hospital, Iganga district, revealing a concerning rate of 58% (CI: 62.47-73.46). This prevalence stands in pronounced contrast to the significantly lower rate of 2.8% reported in a previous study conducted in Agago district, Uganda (Okot et al., 2023)

and is also higher than the national prevalence of 25% documented in the 2016 Uganda Demographic and Health Survey of 2016. Furthermore, this study utilized a cross-sectional design, similar to the community-based, descriptive cross-sectional study conducted in Agago District, (Okot et al., 2023) which involved a sample size of 289 participants while our study had a slightly larger sample size of 292 participants, both studies aim to provide insights into the prevalence and associated factors of teenage pregnancy in their respective populations.

Perceived knowledge on contraceptives was significantly associated with teenager pregnancy where individuals who reported to lack knowledge about contraceptives were 1.28 times more likely to have teenage pregnancy. This may be due to inadequate understanding of contraceptive methods, reliance on myths, and lack of awareness about access. Insufficient sexual education, cultural stigma, and societal taboos further hinder informed decision-making, leading to unprotected sex and increased risk.

Furthermore, the study findings are also similar to those from a community-based cross-sectional study which was conducted among 343 teenagers from 15 February 2020 to 24 March 2020 that showed a significant association between knowledge about contraceptives and teenage pregnancy (Kassa et al., 2021). Therefore, comprehensive education and accessible information on reproductive health are essential to address these gaps, promote contraceptive use, and reduce teenage pregnancies by empowering teenagers with the knowledge to make informed choices.

Employment status of participant was significantly associated with teenage pregnancy after controlling for all the potential confounders. Participants who were unemployed were 1.37 times more likely to have teenage pregnancies compared to those who were employed. This may be due to unemployed participants may face financial instability, limiting access to contraceptives and increasing dependence on early relationships, often leading to teenage pregnancy. Limited economic opportunities may also contribute to low education levels, reducing awareness of reproductive health.

The finding from the present study aligns with those from a cross-sectional study of secondary data analysis using the 2019–20 Gambian demographic and health survey data where total of 2633 weighted 15–19 years old girls were included in the study and it was found out that teenagers who

were un employed were more likely to have teenage pregnancies compared to their counterparts who were employed (Terefe, 2022).

Therefore, empowering teenagers through skills development, income-generating initiatives, and comprehensive sexual education. Integrating reproductive health services into community programs targeting unemployed youth can enhance access to contraceptives and reduce teenage pregnancies.

Age at first sexual intercourse was significantly associated with teenage pregnancies where individual who reported to have had their first sexual intercourse at greater than 17 years were 0.65 times less likely to have teenage pregnancy. Engaging in first sexual intercourse after age 17 reduces the risk of teenage pregnancy due to greater emotional maturity, better decision-making, and increased likelihood of contraceptive use. Delaying sexual initiation often correlates with higher education levels, improving awareness of reproductive health. The findings from the current study are similar to those of the most recent Demographic and Health Survey of 2022 (DHS) datasets of the 12 East African countries where a total weighted sample of 17, 234 adolescent girls who ever had sex was included. Girls who reported to have had sex at early age were more likely to have teenage pregnancies compared to those at late stages of the teenagers (Ochen et al., 2019b). Therefore, promoting comprehensive sexual education and life skills programs that encourage delayed sexual debut, coupled with accessible to contraceptive services for adolescents, to empower informed choices and reduce teenage pregnancies.

## **5.2 Strengths and limitations of the study**

The questionnaires were pretested and modified, written in clear language with no technical terms to control for information bias. Reliance on self-reported data may have introduced bias,

particularly in reporting sexual behavior might have introduced information bias. Some variables like knowledge about contraceptives and social economic status of the parents were not measured using standard tools and this could have introduced information bias. The study did not account for any potential confounders which could have influenced the association of some factors with teenage pregnancy leading to biased results. The study was specific to rural community in Uganda. Therefore, the findings may not be directly generalizable to other setting such as the urban communities. A non-random sampling technique was used to enrol participants and this could have introduced selection bias in the study.

## CHAPTER SIX

### 6.0 Conclusions and Recommendations

#### 6.1 Conclusions

Nearly six in every ten teenage girls attending care at Iganga General Hospital were found to have teenage pregnancy. Perceived knowledge about contraceptive use, employment status and age at first sexual intercourse were the factors that were significantly associated with teenage pregnancies.

#### 6.2 Recommendations

Educating the teenage girls on contraceptive methods and reproductive health should be aggressively pursued through community workshops and discussions. Until the teenage girls seeking care from Iganga Hospital feel emotionally and physically mature, ideally after the age of 17, they should think about delaying sexual activity to lower the risk of unintended births.

The Healthcare professionals of Iganga General Hospital should put in place customized sexual education programs that address the specific needs of these teenagers who seek their care from Iganga general hospital and offer a friendly, accepting setting where they can ask concerns about reproductive health without fear of consequences. It is also essential to improve access to contraceptives by making sure they are easily accessible, reasonably priced, and closely monitored.

To enable teenagers from Iganga General Hospital to make knowledgeable decisions regarding their reproductive health, the Ministry should require that comprehensive sexual education be included in school curricula. Supporting teenage mothers' continuing education is important because it enables them to finish their education and reduces the stigma attached to teen pregnancy.

In order to assess the impact of educational interventions over time and investigate the cultural and socioeconomic elements that lead to teenage pregnancies, future research should be done. Furthermore, using approved tools to gauge factors like socioeconomic level and contraception awareness will improve the accuracy of results and efficiently guide future initiatives. Instead of being applied to the entire nation, recommendations ought to be customized for the particular research region.

## REFERENCES

- Aisevbonaye, A. (2022). *Unplanned teenage pregnancies and their impact on educational progress* National University of Lesotho].
- Ajayi, A. I., & Ezegebe, H. C. (2020). Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa. *BMC public health*, 20(1), 1370. <https://doi.org/10.1186/s12889-020-09488-6>
- Ajisuksmo, C. R. (2021). Why Some Adolescents Engage in Risk-Taking Behavior. *International Journal of Educational Psychology*, 10(2), 143-171.
- Alukagberie, M. E., Elmusharaf, K., Ibrahim, N., & Poix, S. (2023). Factors associated with adolescent pregnancy and public health interventions to address in Nigeria: a scoping review. *Reproductive health*, 20(1), 95. <https://doi.org/10.1186/s12978-023-01629-5>
- Amjad, S., MacDonald, I., Chambers, T., Osornio-Vargas, A., Chandra, S., Voaklander, D., & Ospina, M. B. (2019). Social determinants of health and adverse maternal and birth outcomes in adolescent pregnancies: a systematic review and meta-analysis. *Paediatric and perinatal epidemiology*, 33(1), 88-99.
- Ayanaw Habitu, Y., Yalew, A., & Azale Bisetegn, T. (2018). Prevalence and Factors Associated with Teenage Pregnancy, Northeast Ethiopia, 2017: A Cross-Sectional Study. *J Pregnancy*, 2018, 1714527. <https://doi.org/10.1155/2018/1714527>
- Belachew, T. B., Negash, W. D., Kefale, G. T., Tafere, T. Z., & Asmamaw, D. B. (2022). Determinants of early marriage among married women in nine high fertility sub-Saharan African countries: a multilevel analysis of recent demographic and health surveys. *BMC public health*, 22(1), 2355.

- Bukuluki, P., Kisaakye, P., Houinato, M., Ndieli, A., Letiyo, E., & Bazira, D. (2021). Social norms, attitudes and access to modern contraception for adolescent girls in six districts in Uganda. *BMC health services research*, 21(1), 1040. <https://doi.org/10.1186/s12913-021-07060-5>
- Challa, S., Manu, A., Morhe, E., Dalton, V. K., Loll, D., Dozier, J., Zochowski, M. K., Boakye, A., Adanu, R., & Hall, K. S. (2018). Multiple levels of social influence on adolescent sexual and reproductive health decision-making and behaviors in Ghana. *Women & health*, 58(4), 434-450.
- Chandra-Mouli, V., Lane, C., & Wong, S. (2015). What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Global Health: Science and Practice*, 3(3), 333-340.
- Chemutai, V., Musaba, M. W., Amongin, D., & Wandabwa, J. N. (2022). Prevalence and factors associated with teenage pregnancy among parturients in Mbale Regional Referral Hospital: a cross sectional study. *Afr Health Sci*, 22(2), 451-458. <https://doi.org/10.4314/ahs.v22i2.52>
- Crooks, R., Bedwell, C., & Lavender, T. (2022). Adolescent experiences of pregnancy in low-and middle-income countries: a meta-synthesis of qualitative studies. *BMC Pregnancy Childbirth*, 22(1), 702. <https://doi.org/10.1186/s12884-022-05022-1>
- Fearon, E., Wiggins, R. D., Pettifor, A. E., & Hargreaves, J. R. (2015). Is the sexual behaviour of young people in sub-Saharan Africa influenced by their peers? A systematic review. *Social science & medicine*, 146, 62-74.

- Fortin-Langelier, E., Daigneault, I., Achim, J., Vézina-Gagnon, P., Guérin, V., & Frappier, J.-Y. (2019). A matched cohort study of the association between childhood sexual abuse and teenage pregnancy. *Journal of Adolescent Health, 65*(3), 384-389.
- Gloria, N. (2017). Family structure and teenage pregnancy in Kampala: a case study of Kawempe Division.
- Harada, R., Imoto, A., Ndunyu, L., & Masuda, K. (2024). The reasons for and influences of unintended teenage pregnancy in Kericho county, Kenya: a qualitative study. *Reproductive health, 21*(1), 143. <https://doi.org/10.1186/s12978-024-01872-4>
- Iqbal, S., Zakar, R., Zakar, M. Z., & Fischer, F. (2017). Perceptions of adolescents' sexual and reproductive health and rights: a cross-sectional study in Lahore District, Pakistan. *BMC international health and human rights, 17*, 1-13.
- Jacobs, C. (2019). *Parental educational support for adolescence in single-mother families of a low-income community* Stellenbosch: Stellenbosch University].
- Kassa, B. G., Belay, H. G., & Ayele, A. D. (2021). Teenage pregnancy and its associated factors among teenage females in Farta Woreda, Northwest, Ethiopia, 2020: A community-based cross-sectional study. *Population Medicine, 3*, 1-8.
- Kirchengast, S. (2016). Teenage Pregnancies: A Worldwide Social and Medical. *An analysis of contemporary social welfare issues, 13*.
- Maharaj, N. R. (2022). Adolescent pregnancy in sub-Saharan Africa—a cause for concern. *Frontiers in Reproductive Health, 4*, 984303.
- Maheshwari, M. V., Khalid, N., Patel, P. D., Alghareeb, R., & Hussain, A. (2022). Maternal and neonatal outcomes of adolescent pregnancy: a narrative review. *Cureus, 14*(6).

- Mezmur, H., Assefa, N., & Alemayehu, T. (2021). Teenage Pregnancy and Its Associated Factors in Eastern Ethiopia: A Community-Based Study. *Int J Womens Health*, 13, 267-278. <https://doi.org/10.2147/ijwh.S287715>
- Mezmur, H., Nega, A., & Alemayehu, T. (2021). Teenage Pregnancy and Its Associated Factors in Eastern Ethiopia: A Community-Based Study. *International Journal of Women's Health*, 13(null), 267-278. <https://doi.org/10.2147/IJWH.S287715>
- MoES. (2019). *National Sexuality Education Framework*. <https://scorecard.prb.org/wp-content/uploads/2019/06/Uganda-NATIONAL-SEXUALITY-EDUCATION-FRAMEWORK.pdf>
- Mohammed, A., Donkoh, I. E., Aboagye, R. G., Ahinkorah, B. O., & Seidu, A.-A. (2024). Access to quality contraceptive counselling among adolescent girls and young women in sub-Saharan Africa. *Contraception and Reproductive Medicine*, 9(1), 16. <https://doi.org/10.1186/s40834-024-00267-x>
- Mollborn, S. (2017). *Mixed messages: Norms and social control around teen sex and pregnancy*. Oxford University Press.
- Moshi, F. V., & Tilisho, O. (2023). The magnitude of teenage pregnancy and its associated factors among teenagers in Dodoma Tanzania: a community-based analytical cross-sectional study. *Reproductive health*, 20(1), 28. <https://doi.org/10.1186/s12978-022-01554-z>
- Nabugoomu, J. (2019). School dropout in rural Uganda: stakeholder perceptions on contributing factors and solutions. *Educ J*, 8(5), 185.
- Nagandla, K., & Kumar, K. (2020). Prevalence of teenage pregnancy in 2015-2016 and its obstetric outcomes compared to non-teenage pregnancy at Hospital Tuanku Ja'afar

- Seremban (HTJS), Negeri Sembilan, Malaysia: A retrospective case-control study based on the national obstetric registry. *Malays Fam Physician*, 15(2), 2-9.
- Nartey, E. B., Babatunde, S., Okonta, K. E., Kotoh, A. M., Amoadu, M., Abraham, S. A., Agyare, D. F., Baah, J. A., & Obeng, P. (2025). Prevalence and barriers to the utilization of adolescent and youth-friendly health services in Ghana: systematic review and meta-analysis. *Reproductive health*, 22(1), 58.
- Nguyen, P. H., Scott, S., Neupane, S., Tran, L. M., & Menon, P. (2019). Social, biological, and programmatic factors linking adolescent pregnancy and early childhood undernutrition: a path analysis of India's 2016 National Family and Health Survey. *The Lancet Child & Adolescent Health*, 3(7), 463-473.
- Ninsiima, L. R., Chiumia, I. K., & Ndejjo, R. (2021). Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reproductive health*, 18, 1-17.
- Noll, J. G., Shenk, C. E., & Putnam, K. T. (2009). Childhood sexual abuse and adolescent pregnancy: a meta-analytic update. *J Pediatr Psychol*, 34(4), 366-378.  
<https://doi.org/10.1093/jpepsy/jsn098>
- Nuwabaine, L., Sserwanja, Q., Kamara, K., & Musaba, M. W. (2023). Prevalence and factors associated with teenage pregnancy in Sierra Leone: evidence from a nationally representative Demographic and Health Survey of 2019. *BMC public health*, 23(1), 527.  
<https://doi.org/10.1186/s12889-023-15436-x>
- Ochen, A. M., Chi, P. C., & Lawoko, S. (2019a). Predictors of teenage pregnancy among girls aged 13–19 years in Uganda: a community based case-control study. *BMC pregnancy and childbirth*, 19, 1-14.

- Ochen, A. M., Chi, P. C., & Lawoko, S. (2019b). Predictors of teenage pregnancy among girls aged 13–19 years in Uganda: a community based case-control study. *BMC pregnancy and childbirth*, *19*(1), 211. <https://doi.org/10.1186/s12884-019-2347-y>
- Okigbo, C. C., Kabiru, C. W., Mumah, J. N., Mojola, S. A., & Beguy, D. (2015). Influence of parental factors on adolescents' transition to first sexual intercourse in Nairobi, Kenya: a longitudinal study. *Reproductive health*, *12*, 1-12.
- Okot, C., Laker, F., Apio, P. O., Madraa, G., Kibone, W., Pebalo Pebolo, F., & Bongomin, F. (2023). Prevalence of Teenage Pregnancy and Associated Factors in Agago District, Uganda: A Community-Based Survey. *Adolesc Health Med Ther*, *14*, 115-124. <https://doi.org/10.2147/ahmt.S414275>
- Popoola, O. E. (2021). Traditional review of health and socio-economic implications of adolescent motherhood. *birth*, *4*(1), 69-84.
- Poudel, S., Razee, H., Dobbins, T., & Akombi-Inyang, B. (2022). Adolescent Pregnancy in South Asia: A Systematic Review of Observational Studies. *Int J Environ Res Public Health*, *19*(22). <https://doi.org/10.3390/ijerph192215004>
- Richner, D. C. (2021). *Relationships Between Sexual Health Knowledge, Self-Efficacy, and Trauma on Sexual Risk-Taking Among Women* [Idaho State University].
- Robertson, J. A. (2021). Children of choice: freedom and the new reproductive technologies.
- Saleh, M. A. (2022). Outcomes of teenage pregnancy at Benghazi Medical Center 2019-2020. *International Journal of Science Academic Research*, *3*(3), 358-3602.
- Sama, C.-B., Ngasa, S. N., Dzekem, B. S., & Choukem, S.-P. (2017). Prevalence, predictors and adverse outcomes of adolescent pregnancy in sub-Saharan Africa: a protocol of a systematic review. *Systematic reviews*, *6*, 1-6.

- Sifer, S. D., & Getachew, M. S. (2024). Risky sexual behavior and associated factors among out-of-school youths in Addis Ababa, Ethiopia; mixed methods study. *Reproductive health*, 21(1), 77. <https://doi.org/10.1186/s12978-024-01808-y>
- Smith, C., Strohschein, L., & Crosnoe, R. (2018). Family histories and teen pregnancy in the United States and Canada. *Journal of Marriage and Family*, 80(5), 1244-1258.
- Terefe, B. (2022). The prevalence of teenage pregnancy and early motherhood and its associated factors among late adolescent (15–19) years girls in the Gambia: based on 2019/20 Gambian demographic and health survey data. *BMC public health*, 22(1), 1767.
- Tesfa, D., Tiruneh, S. A., Gebremariam, A. D., Azanaw, M. M., Engidaw, M. T., Kefale, B., Abebe, B., Dessalegn, T., & Tiruneh, M. (2023). The pooled estimate of the total fertility rate in sub-Saharan Africa using recent (2010–2018) Demographic and Health Survey data. *Frontiers in public health*, 10, 1053302.
- Thepthien, B.-o., & Celyn. (2022). Risky sexual behavior and associated factors among sexually-experienced adolescents in Bangkok, Thailand: findings from a school web-based survey. *Reproductive health*, 19(1), 127. <https://doi.org/10.1186/s12978-022-01429-3>
- Theuri, J., & Mutisya, D. N. (2021). Alcohol and drug abuse as ecological predictors of risk taking behaviour among secondary school students in Kajiado North Sub-County, Kajiado County, Kenya. *African Journal of Empirical Research*, 2(1&2), 50-55.
- Tridenti, G., & Vezzani, C. (2017). Pregnancy in adolescence. In *Good practice in pediatric and adolescent gynecology* (pp. 239-259). Springer.
- Tumwizere, G., Nsenga, R., Ndugga, P., & Kwagala, B. (2024). Intention to use modern contraceptives among current nonusers of reproductive age in Uganda. *Contraception and Reproductive Medicine*, 9(1), 67. <https://doi.org/10.1186/s40834-024-00325-4>

- UBOS. (2022). *Uganda Demographic Health Survey , 2022*. <https://www.ubos.org/wp-content/uploads/publications/UDHS-2022-Report.pdf>
- UDHS. (2022). <https://www.health.go.ug/cause/uganda-demographic-and-health-survey-udhs-2022-key-findings/>
- UNPFA. (2021). *Fact Sheet on Teenage Pregnancy 2021*.  
[https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy\\_factsheet\\_3.pdf](https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf)
- Webb, L., Kyaddondo, D., Ford, T., Bergqvist, A., & Cox, N. (2023). Psychosocial health in adolescent unmarried motherhood in rural Uganda: Implications for community-based collaborative mental health education, and empowerment strategies in the prevention of depression and suicide. *Transcultural psychiatry*, 60(3), 537-551.
- WHO. (2024a). *The adolescent health indicators recommended by the Global Action for Measurement of Adolescent Health: Guidance for monitoring adolescent health at country, regional and global levels*. World Health Organization.
- WHO. (2024b). *World Health Organisation Adolescent Pregnancy-Fact Sheet*.  
<https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>
- Widman, L., Choukas-Bradley, S., Helms, S. W., & Prinstein, M. J. (2016). Adolescent susceptibility to peer influence in sexual situations. *Journal of Adolescent Health*, 58(3), 323-329.
- Yakubu, I., & Salisu, W. J. (2018). Determinants of adolescent pregnancy in sub-Saharan Africa: a systematic review. *Reproductive health*, 15, 1-11.

## APPENDICES

### a) Informed consent

**Title of the proposed study: TEENAGE PREGNANCY AND ITS ASSOCIATED  
FACTORS AMONG GIRLS SEEKING ANTENATAL CARE FROM Iganga General  
Hospital Iganga District: A POST-COVID ERA PERSPECTIVE**

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UGANDA CHRISTIAN UNIVERSITY

#### **Background and rationale for the study:**

Teenage pregnancy is a global problem and creates issues for all those concerned about young teenage girls and their children's health and well-being it is considered a serious public health and social problem globally, approximately 95% occurs in developing countries, and this study is going to help assess teenage pregnancy and its associated factors among girls seeking antenatal care from Iganga general hospital Uganda.

#### **A description of sponsors of the research project and the organizational affiliation of the researchers:**

The study hasn't got a sponsor and the researcher is affiliated to Uganda Christian University.

**Purpose:**

The purpose of this study will be to assess teenage pregnancy and its associated factors among girls seeking antenatal care from Iganga General Hospital Uganda. It will consist of collecting data from the consented teenage pregnant girls that seek their antenatal from Iganga general hospital.

**The estimated duration the research participant will take to in the research project:**

The study will be estimated to take 4 months i.e. from May to August 2024

**Procedures:**

- The research assistants will identify pregnant teenagers first, teach them all the necessary information about the study and get the informed consent from them.
- The consented pregnant teenagers will be given a simple questionnaire which the research assistant will help to translate verbally to them and help them to fill it.

**Who will participate in the study:**

The study will involve pregnant teenagers from Iganga General Hospital and a calculated sample size of 292 participants will be involved in the study.

**Benefits:**

Anticipated benefits of conducting the study including possible benefits to the participant, community and the entire world.

**Confidentiality:**

Data will also be anonymized and stored on secure servers or systems, which will be accessed using passwords by the principal investigator only to ensure confidentiality.

Approvals from the local Research Ethics Committee (REC) and Uganda National Council for Science and Technology (UNCST) as entities which may have access to private information that identifies the research participants by name.

**Alternatives:**

Participants should be informed that participation in the study is not mandatory and what possible alternatives are available other than participating in the study.

**Cost:**

The principal investigator will meet all the cost and compensations to the participants throughout the study period.

**Compensation for participation in the study:**

Participants will be refunded with some costs (10,000 UgShs.) in terms of travel and opportunity cost while they come to the study site will be met. (Transport, time and meals.

**Reimbursement:**

No reimbursement like transport to the participants because they will be found at their colleges of study.

**Questions about the study:**

State how participants who have study related questions can reach investigators to answer such questions.

This will be done by giving a 24/7 phone number to the participants and the email.

**Questions about participants rights:**

The participation in the proposed study is voluntary and participants may join on their own free will. Participants also have a right to withdraw from the study at any time without penalty.

**Statement of voluntariness:**

The participation in the proposed study is voluntary and participants may join on their own free will. Participants also have a right to withdraw from the study at any time without penalty.

**Dissemination of results:**

A statement that research participants will get feedback on findings and progress of the study and that any new information that affects the study or data that has clinical relevance to research participants (including incidental findings) will be made available to research participants and/or their health care providers.

**Ethical approval:**

Ethical approval will be obtained from REC

**Consent:**

Statement of consent after understanding the study and a signature portion.

**STATEMENT OF CONSENT**

..... has described to me what is going to be done, the risks, the benefits involved and my rights regarding this study. I understand that my decision to participate in this study will not alter my usual medical care. In the use of this information, my identity will be concealed. I am aware that I may withdraw at any time. I understand that by signing this form, I do not waive any of my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate. A copy of this form will be provided to me.

Name .....Signature/thumb print of participant .....Date .....

Name .....Signature of parent/guardian for minors (If applicable) ...

Date .....

Name ..... Signature of interviewer/Person obtaining informed consent

.....Date .....

**b) QUESTIONNAIRE**

**TITLE: TEENAGE PREGNANCY AND ITS ASSOCIATED FACTORS AMONG GIRLS  
SEEKING CARE FROM IGANGA GENERAL HOSPITAL DISTRICT: A POST-COVID  
ERA PERSPECTIVE**

Please answer all questions to the best of your knowledge and experience. Your responses will be kept strictly confidential.

**Section 1: Demographic information:**

1. Age: \_\_\_\_\_

2. What is your tribe?

a) Baganda

b) Basoga

c) Banyoro

d) Batooro

e) Banyankole

f) Bakiga

g) Alur

h) Other (specify) .....

3. What is your marital status?

a) Single                       b) Married

4. What is your religion

a) Christianity             b) Moslems             c) SDA             d) Others

5. What is your level of education level?

a) No formal education             b) Primary level             c) Secondary level             d) Tertiary level

6. What is your level of employment level?

a) Employed                       b) Non employed

5. At what age did you have your first sexual intercourse?

a) <15             b) 15-17             c) >17

6. How many sexual partners do you have?

a) 1             b) 2             c) 3 and more

7. Have you ever used contraceptive use?

a) Yes             b) No

8. Do you have any knowledge about contraception and safe sex practices?

a) Yes             b) No

9. Do you have any awareness of the risks and consequences of teenage pregnancy?

a) Yes       b) No

10. Do you have any understanding on prenatal care and its importance?

a) Yes       b) No

11. At what age did you get the pregnancy?

a) <19-year       b) Above 19 years

## Section 2: Family factors information

1. How would you describe your family structure?

a) Nuclear family       b) Extended

2. How would you describe the overall relationships and interactions within your family? a)

Good       b) Bad

3. What is your family's socioeconomic background (e.g., income level, access to resources)?

a) High       b) Medium       c) Low

4. Do you feel emotionally supported by your parents/guardians?

a) Yes       b) No

5. How do your parents/guardians typically provide guidance and discipline?

- a) Indirectly                       b) Directly

6. How much time do you spend with your parents/guardians on a daily or weekly basis?

- a) Little                       b) Average                       c) Adequate

7. What is the highest level of education your parents/guardians have completed?

- a) No formal education                       b) Primary level   
b) Secondary level                       d) Tertiary level

8. Do you feel your parents/guardians have the resources to support your educational goals?

- a) Yes                       b) No

**Section 3; Societal Attitudes Societal and social-cultural factors**

1. What are the general attitudes towards teenage pregnancy in your society?

- a) Lack of morals   
b) Shame to  family  
c) Poverty

- d) Forced marriage
- e) Other (specify) .....

2. How do these societal attitudes make you feel about the possibility of teenage pregnancy?

- a) Low chance
- b) Moderate chance
- c) High chance

**Cultural Norms:**

3. Are there any cultural traditions or practices that contribute to teenage pregnancy rates in your community (e.g., early marriage, emphasis on childbearing)?

- a) Yes
- b) No

4. How do cultural expectations about gender roles influence decisions about sex and contraception?

- 
- 
- 
- a) Low
- b) Moderate
- c) High

5. Do cultural taboos surrounding sexuality make it difficult for teenagers to access information or seek help?

- a) Yes
- b) No

**Peer Influence:**

6. How do your friends' attitudes and behaviors regarding sex and relationships influence your own?

- a) Not at all                       b) Somewhat                       c) Very much

7. Do you feel pressure from your peers to engage in sexual activity?

- a) Yes                                       b) No

8. How comfortable are you talking to your friends about safe sex practices and contraception?

- a) Not comfortable                       b) Somewhat comfortable                       c) Very comfortable

**Access to Health Care:**

9. Do you have access to confidential and affordable sexual and reproductive healthcare services?

- a) Yes                                       b) No

10. Are there any barriers that prevent teenagers in your community from accessing these services (e.g., transportation, cost, parental consent laws)?

a) Yes

b) No

11. How comfortable would you feel seeking healthcare services related to sexual health or pregnancy?

a) Not comfortable

b) Somewhat comfortable

b) Very comfortable

**Support System:**

12. Does your community offer any programs or resources that support teenagers facing unplanned pregnancies?

a) Yes

b) No

13. How would you feel about continuing your education or pursuing your goals if you became pregnant as a teenager?

a) Never

b) Possible

[Text box for response]

Thank you for taking the time to complete this questionnaire. Your participation is greatly appreciated!

Note: This questionnaire is for research purposes only. If you have any health concerns or require medical advice, please consult a healthcare professional.

**Olukusa:**

Ekiwandiiko ky'okukkiriza oluvannyuma lw'okutegeera okunoonyereza n'ekitundu eky'omukono.

Ekiwandiiko ky'okukkiriza .

.....

Obulabe, emigaso egizingirwamu n'eddembe lyange erikwata ku kunoonyereza kuno. Ntegedde nti okusalawo kwange okwetaba mu kunoonyereza kuno tekijja kukyusa bujjanjabi bwange obwa bulijjo. Mu nkozesa y'amawulire gano, endagamuntu yange ejja kukwekebwa. Nkimanyi nti nnyinza okuggyayo ekiseera kyonna. Ntegedde nti nga nssa emikono ku ffoomu eno, sikyewaayo ku ddembe lyange lyonna ery'amateeka wabula lirambika bulaga nti ntegeezeddwa ku kunoonyereza kuno kwe nzikiriziganya kyeyagalire okwetabamu. Kopi ya foomu eno ejja kuweebwa.

Erinnya .....Ekiwandiiko ky'Omukozi/Thimb  
eky'Omwetabamu .....Olunaku .....

Erinnya .....Ekiwandiiko ky'omuzadde/omukuza w'abaana abatanneetuuka (bwe kiba nga kituufu) ... olunaku .....

Erinnya..... Omukono gw'omubuuza/omuntu okufuna okukkiriza okutegeerekeka .  
.....Olunaku

olw'omweezi .....

**b) Ebibuuzo .**

Omutwe: Okufuna embuto mu myaka gy'ekivubuka n'ensonga ezikwatagana n'abawala

Okunoonya okulabirira okuva mu Iganga General Hospital District: A post-covid ERA  
Endowooza .

Nsaba oddemu ebibuuzo byonna okusinziira ku by'omanyi n'ebyo by'oyitamu. Eby'okuddamu  
byo bijja kukuumbwa nga bya kyama nnyo.

Ekitundu 1: Ebikwata ku bungi bw'abantu:

1. Emyaka: \_\_\_\_\_ .

2. Ekika kyo kye ki?

a)baganda .

b)Basoga .

c)Banyoro .

d)batooro .

e)Banyankole .

f)Bakiga .

g)Alulu .

H)Ebirala (laga) .....

3.Ekifo kyo eky'obufumbo kye ki?

a)Single b) yafumbirwa .

4. Eddiini yo kye ki .

a) Obukristaayo b) Abasiraamu c) SDA d) abalala .

5. Omutendera gwo ogw'obuyigirize gwe guli gutya?

a) Tewali kusomesa mu butongole b) Omutendera gwa pulayimale C) Omutendera gwa siniya D)

Omutendera gw'amatendekero aga waggulu .

6. Omutendera gwo ogw'omulimu gwe guli gutya?

a) akozesebwa b) atali wa mirimu .

5. Ku myaka emeka gye wasooka okwegatta?

A) <15 b) 15-17 C) >17 .

6. Olina ababeezi bameka?

A) 1 b) 2 c) 3 n'okusoba .

7. Wali okozesezzaako okukozesa eddagala ly'okuziyiza okuzaala?

A) Yee b) Nedda .

8. Olina ky'omanyi ku kuziyiza okuzaala n'enkola z'okwegatta ezitali za bulabe?

A) Yee b) Nedda .

9. Olina okumanya kwonna ku bulabe n'ebiyinza okuva mu lubuto lw'abavubuka?

A) Yee b) Nedda .

10. Olina okutegeera kwonna ku kulabirira nga tonnazaala n'obukulu bwakwo?

A) Yee b) Nedda .

11. Ofunye olubuto lwo lwe wafuna emyaka emeka?

A) <19-Emyaka B) Okusukka emyaka 19 .

Ekitundu 2: Amawulire agakwata ku nsonga z'amaka .

1. Ensengeka y'amaka go wandiginnyonyodde otya?

a) amaka ga nukiriya b) okugaziwa .

2. Oyinza otya okunnyonyola enkolagana n'enkolagana okutwaliza awamu mu maka go? A) kirungi b) kibi .

3. Obubenje bw'amaka go obw'eby'enfuna (e.g., omutendera gw'enyigiza, okufuna eby'obugagga) kye ki?

A) high b) medium c) wansi .

4. Owulira nga owagirwa mu nneewulira bazadde bo/abakuza bo?

A) Yee b) Nedda .

5. Bazadde/abakuza bo batera batya okulambika n'okukangavvula?

a) mu ngeri etali butereevu b) butereevu .

6. Omala mmeka ne bazadde bo/abakuza bo buli lunaku oba buli wiiki?

a) kitono b) average c) ekimala .

7. Obuyigirize obw'oku ntikko bazadde/abakuza bo bwe bamalirizza?

a) Tewali buyigirize butongole b) Omutendera gwa pulayimale .

b) Omutendera ogw'okubiri D) Omutendera ogw'okusatu .

8.Owulira bazadde/abakuza bo balina ebikozesebwa okuwagira ebiruubirirwa byo eby'okusoma?

A) Yee b) Nedda .

Ekitundu 3; Endowooza z'abantu mu bantu n'embeera z'abantu-obuwangwa .

1.Endowooza ki ez'awamu ku lubuto lw'abavubuka mu society yo?

a)Obutaba na mpisa .

b)Shame eri amaka .

C)Obwavu .

d)Obufumbo obukakibwa .

e)Ebirala (laga) .....

2.Endowooza zino ez'omu kitundu zikufuula zitya ku ngeri y'okufunamu embuto mu myaka gy'ekivubuka?

A) Omukisa omutono b) Omukisa ogw'ekigero c) Omukisa omunene .

Emisingi gy'ebyobuwangwa:

3.Waliwo ennono oba enkola yonna ey'obuwangwa eyamba ku miwendo gy'embuto z'abavubuka mu kitundu kyo (e.g., okufumbirwa nga bukyali, okussa essira ku kuzaala)?

a)Yee b) Nedda .

4.Ebisuubirwa mu buwangwa ku mirimu gy'ekikula ky'abantu bikwata bitya ku kusalawo ku kwegatta n'okuziyiza okuzaala?

a)low b) Ekigero c) waggulu .

5.Ebitabo by'obuwangwa ebyetoolodde okwegatta bikaluubiriza abatiini okufuna amawulire oba okunoonya obuyambi?

a)yee b) Nedda .

Okufuga bannaabwe:

6.Endowooza n'enneeyisa ya mikwano gyo ebikwata ku kwegatta n'omukwano bikwata bitya?

a)Si n'akatono b) somewhat c) mungi nnyo .

7.Owulira pressure okuva mu banno okwenyigira mu kwegatta?

a)yee b) Nedda .

8.Oyogera otya nga oyogera ne mikwano gyo ku nkola y'okwegatta n'okuziyiza okuzaala nga tewali bulabe?

a) si comfortable b) somewhat comfortable c) Eyaka nnyo .

Okufuna obujjanjabi:

9.Ofuna obujjanjabi obw'ekyama era obw'ebbeeyi mu by'okwegatta n'okuzaala?

A) Yee b) Nedda .

10.Waliwo ekiziyiza kyonna ekiziyiza abatiini mu kitundu kyo okufuna obuweereza buno (e.g., entambula, omuwendo, amateeka agafuga abazadde)?

A) Yee b) Nedda .

11.Wandiwulidde otya okunoonya obuweereza bw'byobulamu obukwatagana n'obulamu bw'okwegatta oba okufuna embuto?

a)Not comfortable b) somewhat comfortable .

b)Eyagalibwa nnyo .

Enkola y'okuwagira:

12.Ekitundu kyo kiwa pulogulaamu oba eby'obugagga byonna ebiwagira abatiini aboolekera embuto ezitategekeddwa?

A) Yee b) Nedda .

13.Wandiwulidde otya okugenda mu maaso n'okusoma kwo oba okugoberera ebiuubirirwa byo singa ofuna olubuto ng'okyali mutiini?

a) obutasoboka B) kisoboka .

[Ekibokisi ky'ebiwandiiko eky'okuddamu].

Mwebale kuwaayo budde okumaliriza ekibuuzo kino. Okwetaba kwo kusiimibwa nnyo!

Weetegerenze: Ekibuuzo kino kya kunoonyereza kwokka. Bw'oba olina ekikweraliikiriza ku by'obulamu oba nga weetaaga okubuulirirwa abasawo, nsaba weebuuzo ku mukugu mu by'obulamu.

### **c) Community Engagement Plan**

**Title; Teenage pregnancy and its associated factors among girls seeking care from Iganga**

**General Hospital District: a post-covid era perspective**

Objective: The community engagement plan will aim to involve and collaborate with the local community members of Iganga for the research project on teenage pregnancy and its associated factors among girls seeking antenatal care from Iganga general hospital. The primary objectives of the community engagement plan are:

1. **Raise awareness and understanding:** Inform and educate the community about the research objectives, methods, and the importance of addressing teenage pregnancy and improving antenatal care.
2. **Foster community involvement:** Engage community members, including teenagers, parents, healthcare providers, and local organizations, in the research process to ensure their perspectives are considered and valued.
3. **Gather insights and perspectives:** Facilitate open discussions and focus groups to gather insights, experiences, and perspectives on teenage pregnancy, antenatal care, and related challenges within the community.
4. **Build partnerships and collaboration:** Establish collaborative relationships with local leaders, schools, healthcare facilities, and youth organizations to work together in addressing teenage pregnancy and supporting pregnant teenagers.

5. Promote access to resources and support: Identify and promote existing community resources, support services, and educational programs available to pregnant teenagers and their families.
6. Empower youth and community members: Create opportunities for youth involvement, empowerment, and capacity-building through involvement in the research process and related activities.
7. Ensure ethical and culturally sensitive research: Promote ethical conduct and cultural sensitivity throughout the research process, respecting the privacy, confidentiality, and cultural values of the community.
9. Establish long-term community partnerships: Lay the groundwork for sustainable relationships and ongoing collaboration with the community to address teenage pregnancy beyond the research project.

Key Stakeholders:

1. Teenagers: Pregnant teenagers are central stakeholders, as they are directly impacted by the research topic. Their perspectives, experiences, and needs are crucial for understanding the challenges related to teenage pregnancy and antenatal care.
2. Parents and Families: Parents and family members of pregnant teenagers play a significant role in providing support, guidance, and influencing decisions related to antenatal care and pregnancy management.
3. Healthcare Providers: Obstetricians, gynecologists, nurses, midwives, and other healthcare professionals involved in antenatal care are essential stakeholders. Their insights and

experiences can provide valuable perspectives on the challenges and opportunities in providing care to pregnant teenagers.

4. **Community Leaders:** Local leaders, religious leaders, and community representatives can influence community attitudes, policies, and resources related to teenage pregnancy and antenatal care.
5. **Educators and School Administrators:** Schools and educators have a role in providing comprehensive sexual education and supporting pregnant teenagers to continue their education.
6. **Youth Organizations:** Youth-focused organizations and community groups working with teenagers can provide valuable input and support for engaging teenagers in the research process and addressing their needs.
7. **Local Government and NGOs:** Government health departments, non-governmental organizations (NGOs), and community-based organizations involved in healthcare, social services, and youth development are crucial stakeholders for collaboration and resource mobilization.
8. **Research Team:** The researchers and research staff involved in the study are key stakeholders responsible for conducting the research ethically and effectively, and for engaging with the community in a respectful and inclusive manner.

### **Strategies and Activities:**

#### 1. Teenagers:

- Conduct focus group discussions to gather insights and experiences related to teenage pregnancy and antenatal care.

- Organize youth-friendly workshops to educate teenagers about reproductive health, contraception, and antenatal care options.
- Establish a youth advisory group to provide ongoing input and feedback on the research process.

## 2. Parents and Families:

- Host community forums or information sessions to address parental concerns and provide guidance on supporting pregnant teenagers.
- Develop informational materials for parents and families about available resources for supporting pregnant teenagers.

## 3. Healthcare Providers:

- Facilitate roundtable discussions with healthcare professionals to understand the challenges and best practices in providing antenatal care to pregnant teenagers.
- Offer training sessions on adolescent-friendly care and effective communication with pregnant teenagers.

## 7. Community Leaders:

- Engage in one-on-one meetings with community leaders to discuss the importance of addressing teenage pregnancy and seek their support for community awareness campaigns.
- Collaborate with local leaders to organize community events focused on adolescent health and pregnancy prevention.

## 6. Educators and School Administrators:

- Partner with schools to conduct educational workshops on sexual and reproductive health for students and parents.
- Establish a school-based support network for pregnant teenagers to ensure they can continue their education.

#### 7. Youth Organizations:

- Collaborate with youth organizations to organize peer support groups for pregnant teenagers and provide mentorship opportunities.
- Host community events and awareness campaigns led by youth advocates to address stigma and misconceptions about teenage pregnancy.

#### 8. Local Government and NGOs:

- Seek partnerships with local health departments and NGOs to leverage resources and support for pregnant teenagers.
- Advocate for policy discussions and community initiatives to improve access to reproductive healthcare services for adolescents.

By implementing this community engagement plan, we will aim to establish a strong partnership with the community of Mukono, ensuring the relevance of the research project, and promote knowledge sharing and collaboration to improve lung cancer prevention and safety practices in the mining industry.



10<sup>th</sup> July, 2024

Acheng Barbra Brenda  
Uganda Christian University  
0773242988  
Email: [brendahykema@gmail.com](mailto:brendahykema@gmail.com)

## UG-REC-026 APPROVAL NOTICE

To: Acheng Barbra Brenda, Principal Investigator

Re: UCU-REC Application titled: **Teenage Pregnancy And Its Associated Factors Among Girls Seeking Antenatal Care From Iganga General Hospital Iganga District: A Post-Covid Era Perspective**

Application Number: UCUREC-2024-906

Version: 4.0

Type:  Initial Review  
 Protocol Amendment  
 Letter of Amendment (LOA)  
 Continuing Review  
 Material Transfer Agreement  
 Other, Specify:



I am pleased to inform you that the UG-REC-026; UCUREC approved the above referenced application.

Approval of the research is for the period from 10<sup>th</sup> July, 2024, to 10<sup>th</sup> July, 2025

This research is considered minimal risk category.

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and additions to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes. The REC application number assigned to the research should be cited in any correspondence.
3. Reports of unanticipated problems involving risks to participants or other must be submitted to the REC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for REC review.



4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits
5. Regulations require review of an approved study not less than once per 12-month period. Therefore, a continuing review application must be submitted to the REC eight weeks prior to the above expiration date of 10<sup>th</sup> July, 2025 in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. Your research details have been shared with the Executive secretary of Uganda National Council for Science and Technology (UNCST) and you are not required to get clearance since you are a Masters Degree research. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6(e).

The following is the list of all documents approved in this application by UG-REC \_026:

	Document Title	Language	Version	Version Date
1.	Protocol	English	1.0	2024-06-11
2.	Questionnaire	English	1.0	2024-06-11
3.	Informed Consent Form	English	1.0	2024-06-11

Signed and Stamped

Prof. Peter Waiswa.  
UCUREC Chairperson,  
[pwaiswa@musph.ac.ug](mailto:pwaiswa@musph.ac.ug)





# UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

*M/S Iganga Hospital  
Please Accord Support*

26<sup>th</sup> July, 2024

*Permission  
granted*

*J. J. Joseph*

TO WHOM IT MIGHT CONCERN

Dear Sir/Madam,

RE: INTRODUCTORY LETTER FOR ACHENG BARBRA BRENDA

Warm greetings from the School of Research and Post-Graduate Studies, UCU.

This serves to introduce the above named; Acheng Barbra Brenda as our student pursuing a Masters in public health leadership, registration number RS22M07/009.

Brenda is conducting a research as a requirement for the award of the above mentioned degree entitled: **Teenage Pregnancy And Its Associated Factors Among Girls Seeking Antenatal Care From Iganga General Hospital Iganga District: A Post-Covid Era Perspective.**

She has fulfilled all clearance requirements such as getting faculty and Research Ethics Approval from UCUREC; accredited by Uganda National Council for Science and Technology (UNCST). Her work has minimal risks and deemed not harmful to both individual participants and the institution.

Any assistance given to her to achieving this goal will be highly welcome.

Thank you so much.



Yours faithfully,  
Dr. Joseph  
Head, Post Graduate Studies.  
Uganda Christian University  
[jowor.ucu.ac.ug](http://jowor.ucu.ac.ug)



Ref:

6<sup>th</sup> August, 2024

The Director of Post Graduate Studies  
✓ Uganda Christian University,  
**Mukono.**

**RE: ACCEPTANCE LETTER TO COLLECT DATA FROM ANC DEPARTMENT**

This serves to inform you that, on behalf of Iganga General Hospital, I extend my gratitude for your request in collecting data in this facility.

I am delighted to inform you that, Acheng Barbra Brenda has been granted permission to collect data from ANC department for the period from 12<sup>th</sup> August, 2024 to 16<sup>th</sup> September, 2024.

By copy of this letter, the in-charge (Ms. Namusoby Annet) is hereby informed.

Yours in Health Service Delivery



**MEDICAL SUPERINTENDENT  
IGANGA HOSPITAL**

Dr. Anne M. Amate  
**Ag. MEDICAL SUPERINTENDENT  
IGANGA HOSPITAL**

**Copied to:-**

Ms. Namusoby Annet – **In-charge**  
Ms. Acheng Barbra Brenda



# UGANDA CHRISTIAN UNIVERSITY

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UGANDA CHRISTIAN UNIVERSITY

SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

## DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: ..... *1<sup>st</sup> May 2025* .....

Name of Candidate: Acheng Barbara Brenda    Reg. No: RS19M22/009

Title of Dissertation : Teenage Pregnancy and its Associated Factors among Girls Seeking Care from Iganga General Hospital: A Post-Covid Era Perspective

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	The candidate should give an operational definition of teenage pregnancy.	Defined teenage pregnancy clearly in the introduction section of the dissertation.	Pg 3
2	Clearly describe the study population. Did the study consider girls coming from various clinics or only the ANC clinic?	Revised the methodology section to detail the recruitment area which was the Triage area .Methodology section updated with detailed settings.	Pg 24
3	Clarify if the questionnaires were self-administered or assisted, particularly since the	Added clarification that questionnaires were administered	Pg 28

	majority of participants were literate	by a research assistant, and the principle investigator	
4	Mention who conducted data collection, entry, and analysis in the report.	Included information about the individuals responsible for data collection and analysis in the revised Methodology section.	Pg 27
5			

SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	The abstract needs to be summarized to one page.	Revised the abstract to condense the content to one page.	Pg 1 and 2
2	Some paragraphs in the introduction are too long; they need to be split	Split lengthy paragraphs into shorter, clearer sections in the introduction	Improved clarity in the introduction.
3	Needs improvement in referencing as different styles are used.	Standardized referencing style throughout the dissertation per APA guidelines.	References corrected in the document.
4	Objectives need organization from global to local context and the conceptual framework should reflect dependent variables on the left.	Reorganized objectives and adjusted the conceptual framework as recommended.	Pg 4 To 5
5	Data collection process details are lacking.	Added detailed information on data collection methods, including the researcher involved and the training of assistants	Pg 23 To 30

SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1	The researcher was required to explicitly mention the literature that informed the development of the conceptual framework.	Identified and listed specific theories and studies that informed the development of the conceptual framework in the revised section	Pg 14 To 15
2	The write-up was missing an interpretation tool for Lusoga, which should have been complemented by the Luganda tool:	Developed and included an interpretation tool for Luganda tool in the dissertation	Pg 72 To 79
3	It was essential to detail the methods employed in acquiring respondents for the study	Expanded the methodology section to thoroughly outline the strategies employed in respondent recruitment and ensure representative sampling and Recruitment methods detailed in Methodology	Pg 23 To 30
4	Exclusion criteria had to be clearly articulated	Added a section clearly stating the exclusion criteria, specifying	Exclusion criteria defined

