FACTORS FOR HIGH RATE OF TEENAGE PREGNANCY IN UGANDA

Ataro Pamela Ridemta

Uganda

55th International Course in Health Development/ Master of Science in Public Health

September 17th, 2018 – September 06th 2019

KIT (Royal Tropical Institute)

Vrije Universiteit, Amsterdam

Netherlands

FACTORS FOR HIGH RATE OF TEENAGE PREGNANCY IN UGANDA

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

By

Ataro Pamela Ridemta

Uganda

Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The Thesis (**Factors for high rate of teenage pregnancy in Uganda**) is my own work.

Signature: 

55th Master of Science in Public Health/International Course in Health Development (MPH/ICHD)

!7th September 2018 – 6th September 2019

KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam

September 2019

Organized by:

KIT (Royal Tropical Institute)

Amsterdam

In co-operation with:

Vrije Universiteit Amsterdam/Free University of Amsterdam (VU)

Amsterdam, The Netherlands

ACKNOWLEDGEMENT
I am most grateful to the Almighty God who gave me life and led me through successfully.

I wish to thank Orange Knowledge Program scholarship that believed in my capability and awarded me this scholarship which has and will change my life for the better in future. Without this full scholarship, I would surely not have this exposure on my own.

Special thanks also go to the management and staff of Kit who have provided us with a conducive learning environment in all ways throughout the course. Especially my academic supervisor and thesis advisor.

I wish to appreciate the contribution of the 55th ICHD class for the academic and psychological support given to me during trying times.

Special thanks go to my Mum and siblings who encouraged me to take up this golden opportunity and checked on my progress regularly.

Finally, is a very special thanks to my family, children Reuben and Rayna who amidst the psychological ill-health, gave me the strength to move on and take one day at a time

Contents

ABSTRACT
Background

Teenage pregnancy is a huge public health and social problem affecting all countries. In Africa, the highest rates of teenage pregnancies occur in eastern Africa where Uganda registers the highest number of teenage births. Complications of teenage pregnancy and childbirth have contributed to high maternal and child morbidity, mortality further weakening the already constrained economy. This study sought to explore broader factors for the high rates of teenage pregnancy so that strategies can be identified and recommended for prevention of teenage pregnancy in context of Uganda.

Methodology

Literature was reviewed using peer reviewed, grey literature from various sources. The socio-ecological model adopted from Svanemyr et al., 2014 was used to analyze and discuss findings according to the four levels of the model at individual, interpersonal, community and at society levels and following specific objectives.

Findings

Poverty, inadequate information on sexual and reproductive health services, transactional and sexual coercion, peer influence, lack of parental communication, non-contraceptive use, inadequate resources, were most influential factors for high teenage pregnancy in Uganda. Effective strategies to address teenage pregnancy include providing Comprehensive Sexuality education, improving Adolescent Friendly Health Services, programs for socio-economic empowerment and community engagement.

Conclusion and recommendations

Individual factors that contribute to teenage pregnancy are influenced by conditions at interpersonal, community and society levels. Interventions must target all levels. Emphasis should be placed at creating environments that enable teenager have access to services that prevent teenage pregnancy and live better lives.

KEY WORDS: teenage pregnancy, risk factors, Uganda, prevention

Word Count: 12,844

LIST OF ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
CSE	Comprehensive Sexuality Education
ESSP	Education Sector Strategic Plan
ICPD	International conference on Population and Development
ICT	Information, Communication, Telecommunication
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
NAHP	National Adolescent Health Policy
SRHR	Sexual, Reproductive Health and Rights
SRHS	Sexual, Reproductive Health Services
UNAIDS	Joint United Nations Program on HIV Acquired Immune Deficiency Syndrome
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's' Emergency Funds
UPE	Universal Primary Education
VHT	Village Health Team
WHO	World Health Organization
YLP	Youth Livelihood Program

LIST OF TABLES AND FIGURES

LIST OF FIGURES

GLOSSARY

Teenage pregnancy:

Teenage pregnancy is "a teenage girl, usually within the ages of 13-19 becoming pregnant (UNICEF, 2009).

'Natural contraception'

Natural Family Planning refers to a variety of methods used to prevent, or plan pregnancy based on identifying a woman's fertile days (Volgelsong, 2017)

Working Definitions according to World Health Organization

Sexuality:

A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (WHO, 2019).

Sexual health:

It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity (WHO. 2019).

Sexual rights:

Sexual rights include the right to choose one's sexual partner, to control one's own body, to experience sexual pleasure, to not be abused or violated, to freely choose contraceptive methods, have access to safe and legal abortion, have access to information about prevention of sexually transmitted infections (STIs) and comprehensive sexuality education.

INTRODUCTION

Teenage pregnancy is a very huge global social and public health problem. Pregnancies that occur to girls below twenty years result into disability and complications that can be lifelong that eventually slow prospects in development (United Nations Population Fund, 2013). Uganda is one of the countries with the highest teenage pregnancy rates in SSA (Rukundo et al., 2015). Some factors that contribute to teenage pregnancy in Uganda are; rural residency, poor income, child marriage, lack of education regarding sexuality, lack of counselling services against pregnancy and poor health worker attitude(Kyokwijuka, 2009).

As a Nurse by profession with a Bachelor of Nursing Science, I joined the international Rescue Committee in northern Uganda program as a Health Officer from 2011 to 2012 in a post conflict area. It is from there that I first developed interest in Reproductive health while managing survivors of sexual assault, where I decided to further my education in this field to do more about reproductive health. In 2013 I joined Rayna Clinic where we were supported with family planning services by a national NGO Program for Accessible Health Communication and Education (PACE), an affiliate to Population Services International. I worked as a Family planning Service provider and later became a National Family Planning trainer for PACE. The clinic later expanded to Kampala capital city and was taken up by Marie stopes International Uganda which continued supporting with family planning services.

During my work, I realized teenagers reported to being neglected in family planning services and most of them reported being sent away by health workers claiming that they were too young. And others just avoided going to heath facilities for reproductive health services. Teenage pregnancy is high and remains a big public health problem in Uganda. With this information, I choose to write a thesis on factors causing high rates of teenage pregnancy.

This will help teenagers understand and make informed decisions to prevent teenage pregnancy. Recommendations from the thesis will be used Ministry of Health to address teenage pregnancy and work towards achieving SDGs that Uganda has adopted in her national policy.

Thesis outline

This paper contains the following parts: Chapter one talks about the socio-demographic characteristics of Uganda. Chapter two presents the problem statement, justification, objectives, method used and ecological framework. Chapter three analyses findings on factors contributing to teenage pregnancy in context of Uganda. Chapter four presents a critical discussion, conclusion and recommendations

1.0 CHAPTER ONE

This chapter presents information about demography, socio-economic and political situation including health system and key health indicators related to teenage pregnancy.

1.1 BACKGROUND INFORMATION

1.1.1 Demographic data

Uganda is a land locked country located in Eastern Africa. It is boarded by Kenya to the east, Democratic Republic of Congo to the west, South Sudan to the north, Rwanda to the south west and Tanzania to the South (Annex1). According to UNFPA, 2017, World population review 2019, Uganda's population in 2019 is estimated at 45million from 33million in 2013. With a total area of 241,038sq/Km, population density of 189.24sq kilo meter. Eighty four percent of the people reside in the rural area although majority of the major towns are occupied by huge numbers of people. Approximately 73% of women and 75 of men reside in the rural areas. The most populous region in Uganda is the south-central region with 14% and 13% of women and men respectively and Karamoja region being the least populous with both men and women accounting for 2% each (Uganda Bureau of Statistics, 2018).

Uganda has a very diverse ethnicity and reported as one of the countries with the most diverse ethnic populations. The Baganda are the largest ethnic group and make up 16.9% of the total population, Banyankole at 9.5%, Basoga at 8.4%, Bakiga at 6.9%, Iteso at 6.4%, Langi at 6.1%, Acholi at 4.7%, Bagisu at 4.6%, Lugbara at 4.2% and others constitute the remaining 32%. Roman Catholics make up 39.3%, Anglican 32%, Muslim 13.7% and Pentecostal at 11%. Life expectancy on average is at 58.5years for males at 56.7 and females 60.5years. Sex ratio is 1:1 with males being a slight majority. Approximately 73% of women and 75% of men live in rural area. Of the fifteen regions in Uganda, south central region is the most populous with 14% women and 13% men. Karamoja region is least populous with both men and women at 2% each (Uganda Bureau of Statistics, 2018).

1.1.2 Economic Overview

Uganda is predominantly an agricultural economy with more than 50% of the population employed in low paying jobs in agricultural sector. In recent years, there has been slow growth on the economy at 4.5% from 2001-2016 as compared to 7% in 1990s to 2000. This was attributed to adverse climate change, political conflicts in neighboring South Sudan, corruption and restriction of credits in private sector. However, this improved in 2017 due to majorly ICT developments and better agricultural yields. Introduction of Public Financial Management Act in 2015 has seen some progress in policies on management of finances and frameworks although corruption and inadequate procurements are still a huge problem. In Uganda, more than one third of the population lived below 1.9 dollars per day as reported during Uganda Poverty Assessment. The National Household Survey 2016/2017 indicated that the proportion of people living below poverty line increased slightly from20% to 21% in 2013 and 2017 respectively. Northern region however experienced a decrease from 44% t0 33% from2013 and 2017 respectively, making it the poorest region in the country (The World Bank, 2018). The government is working towards achieving its vision 2040 which aims to transform into a middle-income country by strengthening fundamentals of the economy to utilize opportunities available (UNICEF, 2018).

1.1.3 Political environment

The political governance has been under President Yoweri Museveni since 1986 under the National Resistance Movement (NRM) party. Apart from the conflict that lasted for 20yrs in the northern part of the country, there has been relative peace and stability under NRM government and some quality in institution management in the public sector. Uganda has a constant influx of refugees in recent years especially from South Sudan and DRC and presently host about 1.4million refugees. The influx is however affecting service delivery in the already burdened health sector (The World Bank, 2018). Besides, the continuous formulation of new districts due to political interests in these recent years has caused more challenges mainly inadequate resource distribution thus affecting health care and service delivery (Mukasa, 2014).

1.1.4 Employment

According to Uganda Bureau of Statistics (2018), eighty four percent of married women and 99% of married men were employed. Of which 20% of the men were likely to be paid in cash well as 20% of the women were paid in cash and in-kind. This is due to the power imbalance between men and women that is reflected even outside the home.

1.1.5 Education and literacy

Uganda is one of the first African countries to adopt and put in practice the 2030 UN SDGs 4 into the National Planning Framework that led to establishment of ESSP 2017-2020. Implementation of UPE saw an increase in enrollment and favored girls more than boys. Even with achievements and good milestones in UPE the rate at which children drop out of school is still high among girls. Little is also being done in educating children with special needs (Ministry of Education and sports, 2017).

1.1.6 Gender

In Uganda, women of 15 to 19yrs old are twice more likely to encounter Gender Based Violence especially sexually at a period in their life compared to their male counterparts at 22% and 8% respectively. Moreover they are also the group that least report the cases than the older women (Uganda Bureau of Statistics, 2018). Although women representation in parliament is at about 30% and the constitution clearly acknowledges women's abilities, there are some instances where women's' rights are being neglected like inland and property inheritance, marriage and matters of important decision making (Institute of Development Studies, 2019).

1.1.7 Key indicators for health

Unmet need for family planning in sexually active unmarried women was at 32%. Regionally, contraceptive prevalence is lowest in Karamoja at 7% and highest in Bugishu and Kigezi at 43%, North central at 42%, Lango at 41% and South central at 40%. Child mortality for under five at 64 per 1000 live births, infant mortality at 43 per 1000 live births, neonatal at 27 per 1000 live births. Risk ratios shows that the highest risks for child mortality is in those whose mothers are less than 18years and Total Fetility Rate at 5.4 children (Uganda Bureau of Statistics, 2018). The high fertility rate makes it hard for demands for services like health to be fulfilled (Nalwadda et al., 2010). Population growth rate is 3.2, the highest in East Africa. Approximately fifty per cent of the total population of Uganda is below 15 years (World Population Review, 2019).

HIV adult prevalence rate was at 5.9% in 2016 from 7.2 in 2012 (Uganda AIDS Commission, 2016). Unlike men, women are four times more prone to getting infected

with HIV (WHO, 2017). According to (UNAIDS, 2018), about 55.5% of males and 41.2% of females used condoms the last time they had sexual intercourse with someone they were not married to or not staying with. Government gave out 87million condoms in 2012, the number rose to 270miliion in 2015 but it is still not enough considering the huge population.

Maternal mortality by 2015 was 343 per 100,000 live births. This is below the SDG target of 270 per 100,000 and globally Uganda alone accounts for 2% of maternal deaths annually yet not all deaths are registered, data reported was only from HMIS (World Health Organization, 2015).

According to Uganda Bureau of Statistics (2018), birth by teenagers varies by region. Bukedi, Teso, North central and Tooro regions at 31%, Kampala and Kigezi at 17% and 16% respectively **(Annex**)

1.1.8 Health sector situation and services

Health services are offered by both private and public facilities. Public services are structured from village level to National referral. From VHTs at village level, HC ll, HC lll, HC lV, General hospital, Regional Referral Hospitals and National Referral Hospitals. Local Government runs the district hospital and health centres while RRHs are self-accounting and NRHs are semiautonomous. Preventive services are inadequate while curative services are widespread so NGOs and CBOs mainly focus on services aimed at prevention (MoH, 2010). In government facilities in 2008, the number of positions filled by health workers was 51% at overall country level. However regional variations existed; like in northern Uganda it is lower. Quality of health services have been generally low due to shortages of some critical staff like laboratory staff, pharmacy assistants, nutritionists, anesthetists. Staff renumeration and retention is a major problem in health sector because of low salaries and allowances in both private and public sectors of health. Health workers often move abroad for better opportunities. More so, at every level of health system, there is inadequate human resources and general frail health management system (National Health Policy ll, 2010). Health contributed 7.7% of the national total health budget (MoFPED, 2018). This is and has always been way below the Abuja Declaration where 15% government expenditure was to be allocated to health in every African country and Uganda is among the 27 countries in Africa with inadequate progress(World Health Organization, 2015).

Various obstacles still exist in health service delivery in that, apart from low numbers of health workers, even the health workers posted in public areas that are situated in areas that are hard to reach abscond duty, work for few hours and leave the work station faster than expected. Yet when one cadre of staff is missing then service delivery is halted (MoH, 2011).

2.0 CHAPTER TWO

This chapter provides information on the burden of teenage pregnancy. The rationale of the study, objectives and methodology including the strategy for search of Literature. Conceptual framework used.

2.1 PROBLEM STATEMENT

Globally, about 11% of all annual births involve adolescents aged 15-19 years. In Africa, teenage pregnancy is highest in Eastern Africa at 21.5% and lowest in northern Africa at 9.2% (Mullu-Kassa *et al.*, 2018). Uganda has one of the highest teenage pregnancy rates in SSA (Rukundo et al, 2015). Uganda is ranked number one in East Africa registering the highest births for girls below twenty years followed by Tanzania and Kenya (Neal, Chandra-Mouli and Chou, 2015).

In Uganda, one out of four females aged 15-19years has had a child (Leerlooijer et al, 2013). Teenage pregnancy and child birth still remain a big public health and social problem (Rutaremwa, 2013). The percentage of teenagers from ages 15-19years who gave birth or are pregnant with their first child declined from 31% in 2001,25% in 2006, 24% in 2011 and increased slightly to 25% in 2016 (Uganda Bureau of Statistics, 2018). Girls from the rural areas have children earlier than those in urban areas at 24% and 21% respectively. Regionally, Eastern, East central and North eastern parts of Uganda have the biggest percentage of teenage pregnancy at 30% compared to other regions (UNICEF, 2015b).This was observed in Butaleja in eastern Uganda where 80% of mothers who attended ANC services were teenagers (Akanbi, Afolabi and Aremu, 2016).

Some factors that contributed to teenage pregnancy in Uganda as reported by Kyokwijuka (2009) include rural residency, poor income, child marriage, lack of education regarding sexuality, lack of counselling services against pregnancy and lack of privacy by health providers during service provision to teenagers which lowers teenager demand of services exposing them to risky sexual behavior eventually leading to teenage pregnancy. Teenage mothers in Uganda especially those unmarried have many challenges like dropping out of school or having no education, they suffer complications of pregnancy, still birth and stigma in the areas they live. It is also evident that the rates of child mortality are higher among girls whose mothers are teenagers than in those with older mothers (UNICEF, 2015b). Furthermore, teenage pregnancy has also led to complications resulting from unsafe abortions where teenagers suffer most (Byamugisha, et al, 2006). More so teenagers are more at risk of adverse effects of pregnancy and childbirth (Rutaremwa, 2013). These complications of pregnancy and adverse effects of childbirth have massively contributed to the high maternal mortality in Uganda at 356 in 2016 (Uganda Bureau of Statistics, 2018). Apart from pregnancy alone, STIs including HIV have been registered as higher among the young people due to their risky sexual behavior which stipulates a big public health situation (Ministry of Health, 2015)**, c**ontributing to the relatively high HIV prevalence at 5.9%. Girls between 15-24 yrs. have four-times higher chance of getting infected with HIV than other age groups (WHO, 2017).

The burden of caring for teenager and child morbidity after teenage pregnancy and childbirth further weakens the already resource constrained development in Uganda in terms of unnecessary government expenditure, low productivity, high disability adjusted lived years among others. So, this study explores broader factors behind high rates of teenage pregnancy in Uganda, so that measures can be identified to tackle this enormous public health and social problem.

2.2 JUSTIFICATION

In Uganda, more needs to be done about teenage pregnancy because good progress was realized as it decreased from 41% in 1995 to 31% in 2000 then to 24% in 2006 and 2011 (Atuyambe et al., 2015). However, this has increased to 25% according to (UBOS and ICF: 2017) high.

Some NGOs have collaborated with government to tackle teenage pregnancy but most of the programs have not yet registered a significant impact at various level (UNICEF, 2015b). There is no single study that has exhausted the factors for teenage pregnancy in Uganda. Because of this increase, analyzing factors that contribute to teenage pregnancy is crucial and identify effective strategies which should be recommended to Ministry of health and other relevant ministries to collaboratively address this social and public health burden.

2.3 GENERAL OBJECTIVE

Explore underlying factors for teenage pregnancies among girls of 15-19 years in Uganda and recommend strategies to MOH to address teenage pregnancy.

2.4 SPECIFIC OBJECTIVES

1. To analyze factors contributing to teenage pregnancies in Uganda.
2. To identify effective practices from Uganda and other countries to prevent teenage pregnancies
3. To recommend strategies to ministry of health in Uganda in preventing or reducing teenage pregnancy

2.5 METHODOLOGY

A review of literature and desk study was used to explore factors for teenage pregnancy in the context of Uganda, findings were analyzed, discussed and strategies that contribute to preventing teenage pregnancies in Uganda were identified and recommended. On few occasions, my observation during my working experience as a contraceptive service provider was used in the findings.

2.5.1 Search Strategy

Search was initially

The table below summarizes the strategy used for search of literature with reference to the objectives. It pointed out the sources of data and the important search words used.

Table 1: Search table

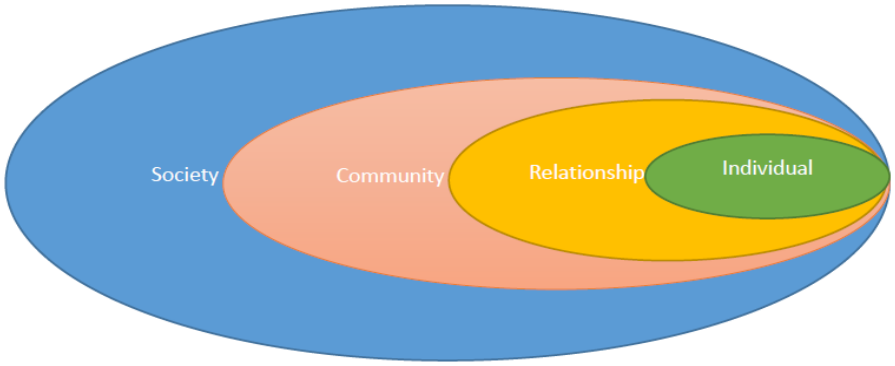
Specific objective	Sources	Search words
➢ Analyze factors contributing to teenage pregnancy ➢ Identify effective practices from other countries or NGOs	Published, peer reviewed articles and grey literature from; Google scholar, Google, Pubmed, VU library, Science direct, Government survey and institutional reports, NGO reports, National and international guidelines, Conference reports, Media articles.	teenager, teenage pregnancy, causes, determinants, risks, adolescent sexual and reproductive health services, health worker attitude, Uganda, Sub Saharan Africa, cultural, reproductive health rights, interpersonal, socio economic, child marriage, policies, transactional sex. Parenting, society,

that can be replicated in Uganda in preventing teenage pregnancy. ➢ To recommend strategies to Ministry of Health in addressing teenage pregnancy		individual, gender norms, inequality, community South Africa, Malawi, Kenya, Ethiopia, effective practices and teenage pregnancy. prevention

2.5.3 Conceptual framework

For this literature review the ecological model was chosen as a model to explore the factors that determine the behavior and teenage outcomes to the behavior of the teenagers, in this case being teenage pregnancy. This is because teenage pregnancy is influenced by a variety of factors, on different levels which can be clearly analyzed using the four levels of the socio-ecological model. Teenagers ability to make decisions as regard to their sexuality is influenced by factors on an individual, relationship, community and societal level (Bastien, Kajula and Muhwezi, 2011). Factors around an individual like Political, socio economic, community contexts influence an individual and his/her relationships. Therefore, it is important to consider these influencers when exploring factors that affect sexuality and lead to teenage pregnancy. The socio-ecological model was also used to develop strategies to address teenage pregnancy it implies that effective strategies need to be executed at all these levels (Rijsdijk, 2013). The Bronfenbrenner's model was considered but not used because it explains how intrinsic make up of a child and his environment interrelate and determine his/her development but it does not stress the active role the child plays in his or her own growth and development (Bronfenbrenner, Urie, Morris, 2006), which is very important when determining behavior of a person. The socio-ecological framework was adapted from Svanemyr *et al.* (2014) in a study to create an enabling environment for SRHR for adolescents. No adjustments were made to the model.

Fig 1: Ecological framework for analyzing factors for teenage pregnancy.



Source: Svanemyr et al, 2014

2.5.3 Limitation of the study

The literature reviewed was only in English as it is the National language in Uganda and most studies done are written in English. Literature review only relied on findings from other researchers and was based on published and unpublished literature. Search was limited from 2004 when the first NAHP was adopted to date.

3.0 CHAPTER THREE

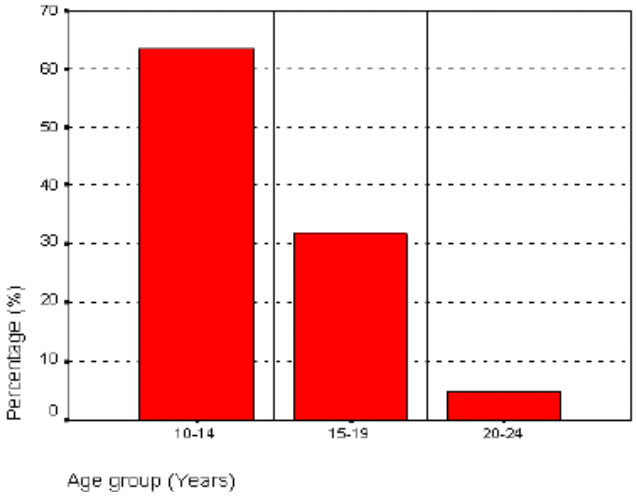
This chapter explains the findings on factors contributing to teenage pregnancy in Uganda using the ecological framework adapted from (Svanemyr et al, 2014). It also outlines effective strategies from Uganda and other countries on prevention of teenage pregnancy.

3.1 Individual level factors

3.1.1 Age at first sexual intercourse

Girls in Uganda start sexual intercourse earlier, median age of 16.9 years compared to boys at 18.5 years, one in five women start sexual intercourse before their 15th birthday while 64% ever had sex by 18 years. (Uganda Bureau of Statistics, 2018). During adolescence, girls experience rapid body changes and they are ignorant about the act and consequences of their sexual encounter which usually takes place forcefully (João and Mwolo, 2017). A study in Nigeria to assess the cause and effect of teenage pregnancy, reported that during adolescence, alterations in brain processes changes emotions and if the girl is not supported by her family, she may search for support from the opposite sex eventually causing teenage pregnancy (Ogori, Ajeya and Yunusa, 2013). Some girls have sexual intercourse as early as 10 years claiming they want to explore their skills (Kyokwijuka, 2009). In a study to assess risk factors for adolescent pregnancy in Kabale District as showed among adolescents, sexual debut was highest between 10-14 years. (see Figure 2).

Table 2: Showing age at first sexual intercousre in Kabale District (Uganda)



Source: (Kyokwijuka, 2009)

A similar study by Rutaremwa (2013) in the same region found similar findings: the results indicated that six percent of adolescents had a sexual encounter as early as 9 years and below. Green et al, (2009), reported in a focused group discussion with parents and teachers about adolescent sexuality that girls are increasingly involved in early sexual intercourse, especially among unsupervised girls in boarding school.

3.1.2 Age at start of contraception

The age at which a girl starts contraception influences future.. The study carried out in Naguru Teenage Centre in Kampala noted that there was a relation between the age a teenager started using contraception and when they got pregnant. Teenagers who started using contraception at 13 years got pregnant earlier as they got tired of using it towards the late stage of adolescence. This prompted them to explore sexual experiences without contraception further exposing them to teenage pregnancy (Akanbi, Afolabi and Aremu, 2016). Inconsistent use of contraceptives was reported to be linked to teenage pregnancy (Ahikire and Madanda., 2011).

3.1.3 Sexual behavior

There was an increase of concurrent sexual relations among teenage boys and girls. The reasons for this increase are not understood but result in public health problems like unplanned pregnancies that reduce quality of life (Nalukwago et al, 2018). Evidence showed that fertility and consequent sexual behavior of a girl depends on her genes and evolutionary factors (Cherry, 2014). Adolescents are known to be the most active group in the population and are highly prone to behavioral changes towards sex (Agardh, Tumwine and Östergren, 2011). Emanating from risky sexual behaviors, unplanned pregnancies are common among adolescents (João and Mwolo 2017). Seventy percent of the teenage students had many sexual partners because of risky sexual behaviors as noted by Ayalew, Mengistie and Semahegn (2014). Idleness among teenagers has exposed them into sexual relationships as adolescents who stopped schooling reported that they often involved themselves more in sexual intercourse and consequently got pregnant (Ministry of Health, 2017).

3.1.4 Information on sexuality

It has been reported that countries that do not openly discuss sexual information have increasing new cases of teenage pregnancy (Lule et al, 2013). This is true with Uganda where Råssjö and Kiwanuka, (2010)- in a study conducted in slum areas of Kampala and Wakiso on socio-cultural influence on sexuality- noted that young people lacked information and life skills to empower themselves and handle issues related to sexuality. If they were given the knowledge, they would teach other peers to acquire and learn about sexuality and wellbeing. Kyoheirwe (2011) confirmed this as she noted that teenage girls had inadequate knowledge about sexuality issues. Further, an examining of parents and teachers observed that sexuality education offered at home and in schools to adolescents is very limited thus exposing them to teenage pregnancies.

3.1.5 Use of alcohol and other substances

Use of alcohol is a common habit among adolescents in Uganda and was reported higher among males than females. However, it has been also noted that girls in the urban areas drank more than the males at 41% and 20.7% respectively (Ministry of Health, 2017). The ability to negotiate safe sex is compromised when someone is under influence of alcohol and makes it harder to resist and defend against forceful sexual advances of the males (Tusiime et al., 2015). These are some of the problems adolescents involve themselves in as explained by an out of school male that *'..most of the youths do not have what to do, they resort to taking alcohol, opium, cigarettes and marijuana. Even girls think it is today's style and in so doing they meet those boys who have taken opium along the roadside and they force them into sex.p.7.'.*

In support, is a study conducted by Klepp et al (2008) which indicated that adolescents indulge in high-risk behaviors like substance abuse and transactional sex, because they stay on the streets. Pressure from age mates, their desire to know and try something new, and the way their parents behaved were also factors that drove them to start drinking alcohol (Ministry of Health, 2017). "When a girl takes a lot of alcohol and gets drunk, men may use her and she ends up with an unwanted pregnancy and she cannot even think of contraceptives, since she will be drunk, p.21."

3.1.6 Contraceptive use

In Uganda, young women who do not desire to have children and do not use contraceptive are at higher risk of unwanted pregnancies (Guttmacher Institute, 2017). Knowledge was about contraception was high in both men and women as over ninety percent of them knew at least one contraceptive method. Contraceptive Prevalence Rate among unmarried sexually active women was at 32% (Uganda Bureau of Statistics, 2018) lowest in East African region where by 2014 it was 34%, 46% and 52% in Tanzania, Kenya and

Rwanda respectively (Andi et al, 2014). These figures confirm the low contraceptive use and contributes to the increase in teenage pregnancy particularly among adolescents (Uganda Bureau of Statistics and, 2007). A study was carried out in Uganda to better understand the unclear reasons why women despite knowledge about contraception do not use them. Answers to that were; being younger (22 years and below), initiation of sex at an early age below 16 years, and residing in a rural areas (Nalwadda et al, 2011). Health influence contraceptive use among girls. In a study conducted among health providers regarding contraception by young people, about one third of the health providers agreed to not giving contraceptives to any child below 18 years, those still at school or not living with a partner and those who have not had a child yet. This is contrary to the policy which do not give any of such restrictions when offering services (Mehra et al., 2012).

A study done to assess obstacles and enabling factors to contraception among adolescents found that socio-cultural barriers block adolescents from obtaining contraceptives. Most adolescents may not have the money to buy the contraceptives especially when they are not married. More females than males reported fear or embarrassment for purchasing contraceptives. Gender power relations also affect use of contraception as reported in a study where young married women said their partners always reject family planning. However, some men also indicated that women themselves resist contraception, thinking that if they used contraception, they would become infertile later (Nalwadda *et al.*, 2010).

3.1.7 Education

It is evident that, education and other opportunities for better life of women have increased globally (Guttmacher, 2013). Women who have higher education have improved knowledge and power to communicate better and make decisions in all areas from family to national level while women with no education often resulting from dropout from school get pregnant or marry early (HEPS Uganda, 2013). Uganda introduced Universal Primary Education (UPE) program in 1997 with a core mandate for equal enrollment and completion of primary school, more so promoting girl child education (Makate and Makate, 2018). However, girls still dropout of school especially in upper primary. This is evident as only 20% of girls who reached secondary school get pregnant compared to 50% of girls who did not have education or ended in primary level getting pregnant (Uganda Bureau of Statistics, 2018). Further studies revealed that myths and misunderstanding about menstruation prolongs stigma thus a big factor for school dropout among adolescent girls leading to idleness and consequently teenage pregnancy (Kirk and Sommer, 2004). In a bid to find out other reasons that led to drop out from schools among girls, a study done in Northwestern Uganda where over forty percent of girls reported lack of money to cater for school needs (International centre for research on women and Forum for African Women Educationalists Uganda, 2014).

3.2 Interpersonal relationships

3.2.1 Sibling and or peer influence

Akanbi, Afolabi and Aremu (2016), found that teenagers whose siblings ever gotten pregnant during teenage years had a higher chance of being sexually active and getting pregnant. As families embrace and consider it a normal practice, it becomes learned behavior and easily passed over to the teen who saw their elder siblings as role models. To support this, a study was done to assess the impact of maternal adolescent childbearing and older sister's teenage pregnancy on a younger sister. Results showed that pregnancy occurred three times more among teenagers whose mother or elder sister had a history of teenage pregnancy (Wall-Wieler, Roos and Nickel, 2016). More so, a study carried out in South Africa pointed out that influence from peers that fell pregnant earlier was a big contribution towards teenage pregnancy (Thobejane, 2015). Peers have strong influence

on their fellow age mates to have unprotected sex and resulting into teenage pregnancy (Ochen, Chi and Lawoko, 2019).

3.2.2 Parenting and relations with teenagers

Parental guidance is very crucial in growth and development of children. In Uganda, a study was carried out to explore teenagers' views on pregnancy, teenagers claimed that parents were responsible for teenage pregnancy. Many observed that some parents were very easy going while others were so difficult and could not give them what they wanted. They engaged in sex in exchange for commodities. Laxity of parents encouraged girls to freely go to places like dancing halls, night prayers and parties or watch pornography which makes them start relationships leading to sexual intercourse and pregnancy (Sekiwunga and Whyte, 2009). Parents on the other hand noted that they lacked skills on how to talk, often feel shy and sexuality talks are restricted within the community (Ayalew, Mengistie and Semahegn, 2014). Talks about sexuality matters are dictated and often directed towards the adolescent as opposed to creating a dialogue between adolescent and parent as reported by Bastien, Kajula and Muhwezi, (2011). A similar study by Kok et al (2017) in Eastern Uganda revealed that most often teenagers felt better discussing sexuality and sexual health matters with their colleagues, boyfriends and partners and not with their parents. The study further indicated that parents did not have time for them as said by one of teenagers that "..*Some parents make themselves so busy, some even fear to talk about sexuality with their children p.45."*. Kyokwijuka (2009) in a study to identify risk factors for adolescent pregnancy in kabale district reported peer pressure as the biggest influence that drive adolescents into sexual intercourse as seen in Table 3.

Table 3: Distribution of peer influence among adolescents

Characteristics	Frequency	Percentage
Party	30	13.3
Drunkardness	10	4.4
Reward	60	26.7
Rape	7	3.1
Curiosity (peer influence)	106	47.1
Others	12	5.3
Total	**225**	**100.0**

Source: (Kyokwijuka, 2009)

If communication of sexuality issues between parents and children was present and good, it could provide guidance and prevent adolescents from risky sexual behaviors like early sexual intercourse, having sex and decrease the number of times they have sexual intercourse which would prevent teenage pregnancy (Markham et al, 2010).

3.2.3 Transactional sex and sexual coercion

In Uganda, transactional sex and sexual coercion are common. In a facility-based cross sectional study by (Tusiime *et al.*, 2015) to determine prevalence of sexual coercion among pregnant teenage girls in Kampala showed prevalence of sexual coercion higher in girls between 15 to 19 years, those who had low education, not married and those who had much older male sex partners

Renzaho et al, (2017) found that 34.3% of adolescents reported that it was fine for a girl to be forced into sexual intercourse. More than 70% noted that sexually harassing a girl was assumed to be okay. According to teenage girls in a study in Rakai district in Uganda,

girls did not have power to decide on issues related to sexual intercourse unless they were married (Wagman et al, 2008). Transactional sexual partners are linked to bad habits and behaviors like substance abuse, forceful sex or fights, having concurrent sexual relations and practicing unsafe sex (Stoebenau et al, 2016). Sexual coercion and power relations are evident in cross generational sexual relations; a situation where a girl has sexual relationship with an older man is also widespread and is most often for transactional reasons with hope of financial gain from the girl or her family. Consequence teenage pregnancy and the viscous cycle of poverty continue. (Bantebya et al., 2014), Batwala et al, 2006).

3.3 Community factors

Community factors are factors that influence individual factors from where the adolescent girl lives.

3.3.1 Place of residence

Place of residence whether rural or urban influences teenage pregnancy. In Uganda, girls from rural areas have children earlier than those in urban areas at twenty-four and twenty-one percent respectively (UNICEF, 2015), that teenagers who lived in rural areas were more likely to become pregnant compared to their counterparts in urban areas. This was because teenagers from rural areas are less educated and have limited access to sexual health services than their urban counterparts. The lack of skilled staff at the lower community health care levels to provide preferred contraceptive method of choice in rural areas could be a reason to explain this (Neal, Chandra-Mouli and Chou, 2015). This is further supported by Wado, Sully and Mumah, (2019) who found out that majority of adolescents whose family resided in rural areas had low income were at a higher risk of unplanned pregnancy because they lost hope of ever prospering in the future. Place of residences also affects contraception where in rural areas, use of contraceptives among teenagers was two times lower than among their counterparts in the urban areas (Nalwadda et al, 2010). As evident in a study that assessed contraceptive use, seventy-five percent of adolescents who lived in urban areas used contraceptives compared to forty-three percent in the rural areas (Batwala et al, 2006). Another factor that contributed to teenage pregnancy was living in-conflict areas and in borders where young girls are more vulnerable to sexual violence. This is particularly common in northern Uganda and Kasese regions among girls fleeing conflict are at higher risk of sexual coercion because due to being refugee. (Ahikire and Madanda, 2011).

3.3.2 Child marriage

Child marriage is a strong factor that has been linked to teenage pregnancy. Child marriage is widespread in Uganda. Parents in a study by Rutaremwa (2013) assessing factors for adolescent pregnancy reported that parents organized the marriage for their daughters themselves. Some girls were also being persuaded by their own parents to get jobs like bar attendants that expose them to men and put them at risk of early pregnancy and pregnancy before marriage. The same study cited child marriage as a way of maintaining status and prestige in the community because the act of marriage is considered a form of respect for families and parents would also want to gain financial benefits through bride price (Green et al, 2009). Interestingly, a widespread public view in some areas in Uganda supports early marriage for girls and considers it normal. To them, marriage if the girl was not schooling or did not have a job was a financial sustainability for her and her family (Sekiwunga and Whyte, 2009). Virginity is considered a form of purity and if a girl reaches puberty the parents start getting worried about her sexual behaviors, so push her to marriage to protect family honour (UNICEF, 2015a).

3.3.4 Myths, Misconceptions and fear

There are a lot of myths and misconceptions around use of contraceptives. In a study to explore obstacles and enabling factors for contraception use among young people in Uganda. Common was fear for contraception making them incapable of giving birth, burns eggs or builds up in the reproductive system and develops into swellings as said by one unmarried teenager "*.. Family planning causes abdominal swelling in the uterus and causes cancer, my in-law was using those methods and she was operated because of this. They removed fat and contraceptives… when you take pills, they pile in your body.. that is why I can't use family planning… p.6*" . Fear was further reported in a study to understand sexual and reproductive health needs of adolescents by Atuyambe et al (2015) that adolescents expressed fear in picking up condoms from facilities shared with adults as they could come across their family members.

Both men and women had a perception that condoms remained in the reproductive system of the woman , others said condoms have holes that let sperms go through, the sizes of condoms were not appropriate and lubricants that come with condoms caused disease and even death consequently avoiding contraceptive use thus increasing risk of early unplanned pregnancies (Nalwadda *et al.*, 2010). However, except for condoms, it has been reported in a study by Akanbi et al (2016) that majority of Ugandans regardless of education are ignorant and have a misconception about contraceptives.

3.3.5 Socio-cultural norms

In some areas of Uganda, there are cultural norms where it is anticipated that girls should get married at 18 years, leave school and get pregnant immediately after. If she did not get pregnant soon, she was labeled infertile. In the same study, adolescents themselves deviated from this perception and reported having a desire to wait longer after they have finished their education (Maly et al, 2017). Norms are so strong in some communities that, issues about contraception are not welcome by community members especially elders who claim it is the reason their women are getting diseases like cancers Akanbi et al (2016).

From my long experience in reproductive health in Uganda, some communities believe a girl is ready for marriage at first menstrual cycle, this makes girls to engage in sexual intercourse in preparation for marriage at the age below 20 years. Socio-cultural and gender norms put these girls at a disadvantage and are not to make decisions about issues relating to sexuality. Often these girls are forced into marriage or getting pregnant against their will when they report not being ready for marriage (Maly *et al.*, 2017). Some culture goes against the wish of the young girls to plan for their future and be financially empowered to better nurture their children as decision solely lie with the community.
In addition, the role of the "*senga*", a paternal auntie who teaches girls basic sexual pleasure skills to sexually entice their partners often done in central Uganda from puberty has been criticized to motivate adolescents to have sexual intercourse (Green et al, 2009).

3.4 Society factors

3.4.1 Poverty

Poverty has been known to have a strong influence on the occurrence of teenage pregnancy among other issues, considering that without money people do not feel worthy. This is well reflected in a study of Kyokwijuka (2009) on factors for adolescent pregnancy in Kabale as stated by one teenage girl, *"… since you have no job and hence no money and yet you know the needs of girls, any boy who has some money is more than welcome. Since you want means of survival..'* Another study participant added that, *"… you also plan to retain this man by making sure you bare him a child as a means of obtaining financial support..."* therefore poverty drove girls into sexual encounters as they lack basic desires for personal use which increase their risk to teenage pregnancy (Ahikire and Madanda., 2011).

In east Africa, lack of income has been found to be strongly linked to teenage pregnancy as teenagers in higher income families take time to get pregnant unlike those in families with inadequate family income (Odimegwu and Mkwananzi, 2016). In some cases, parents choose to marry off their daughters early to relieve themselves from the burden to take care of the girls, because of inadequate family income (Parsons et al, 2015).

3.4.2 Gender norms and roles

In Uganda, the amount of education and information that girls get regarding their sexuality is limited. That is why they are more at risk of getting pregnant and consequently dropping out of school in comparison to those who attend school and have some knowledge SRH. These gender imbalances affect girls because they are not expected to give their opinion on safe sex practices. Due to cultural perceptions, discussions concerning sexuality is not allowed (Burns, 2011). This is in concurrence with Ninsiima et al*.* (2017) who reported that the unequal power relations and gender norms which are exercised from childhood increase vulnerability of girls to early pregnancy, sexual coercion and diseases. Among the 'Bantu", a girl is expected to kneel before her husband or males, and this instantly puts her as a subordinate to the man. There is lots of myths and misconceptions about contraceptives that is widespread, perhaps the reason for low contraceptive prevalence rate which evident among many women regardless of educational status. (Akanbi et al, 2016). These norms make negotiation for safe sex harder due to the expectations that girls must always obey what males tell them. A study conducted in fourteen secondary schools in central Uganda showed that socially constructed gender norms make girls sexually vulnerable and subordinate to boys who are considered dominant regarding sexuality (Kyoheirwe, 2011). These inequalities in gender have resulted to lack of autonomy among women. It has led to the inability of expressing and controlling sexual matters, which further exposes them to teenage pregnancy (Boonstra, 2007).

3.4.3 Access to contraception

Access and use of contraceptives for all people has been well stipulated in the family planning policy of Uganda yet many young people have never utilized the services. Many young people also lack or have little knowledge and awareness on prevention of pregnancy. This has kept them at risk of unplanned pregnancies often resulting into complications of ill health and deaths. (Nalwadda et al, 2011). Lack of knowledge regarding contraceptives was noted as a barrier for contraception especially for those out of school (Batwala et al, 2006). Yet not enough is being done in provision of sexual and reproductive health information and services for teenagers (Nalwadda et al, 2010). Health worker negative attitude towards contraception for adolescents have immensely contributed to the high numbers of teenage pregnancies among girls (Kiapi-iwa and Hart, 2004). Faith based health facilities provide modern contraceptives unlike the ones owned by Catholics (Batwala et al, 2006). This is because use of artificial contraception is against the teaching of the catholic church as they only emphasis abstinence till marriage and natural contraception, while natural contraception emphasized by the Catholic church is not applied by many women (Nakiboneka and Maniple, 2008).

3.4.4 Policies and Laws

Uganda has several policies which aim to emphasize and improve wellbeing of adolescents, however this objective has not been fully achieved (Renzaho *et al.*, 2017). Many of these policies have been established to create enabling environments especially for young women that will protect or prevent them from unintended pregnancies. These include National Adolescent Health Policy, Sexual Reproductive health Minimum package among others. Some were developed to enhance enabling environments like National Adolescent Health policy, which was established in 2004 and revised in 2010 to solve teenage concerns (Rutaremwa, 2013). Recently in 2018, the National sexuality framework was launched with an aim to establish an important national path to offer sex education in

schools in conjunction with other policies that are already present. However, these policies are sometimes not clear or wrongly interpreted by the population making it hard for women and health workers to understand the options (Guttmacher, 2013). Besides, these policies are not equitably distributed across the nation. So, health workers may not know what exactly to do when adolescents approach them and instead send them away (Advancing Partners & Communities, 2016). It is also important to note that politicians often interfere a lot with these policies by prohibiting good moral and ignoring facts, and avoiding consideration of rights and erode the principles regarding sexuality of young people (di Mario and Joffe 2007). Laws in Uganda are not being followed by institutions and the community. Besides, some policies are old and need to be reviewed and revised to improve health, legal and social service delivery (Ochen, Chi and Lawoko, 2019)

3.4.5 Health services

Adolescents have a right to access and utilize reproductive health services from health facilities just like other groups of people (Ministry of Health, 2012). In a study to understand sexual and reproductive health needs among adolescents, over ninety percent of both male and female adolescents expressed that employing a youth counselor was important to guide them on how to handle sexuality matters. Inadequate number of qualified health workers in adolescent friendly services make it hard to receive quality reproductive health services (Nabukeera Madinah, 2016). Inadequate funding for adolescent reproductive health services has resulted to fewer numbers of adolescent friendly services that are not equally distributed countrywide thus affecting accessibility (Rutaremwa, 2013). Reproductive health issues like HIV epidemic were successfully tackled but services like contraception and safe motherhood have not yielded good outcomes that have affected demand for these services (Ndyanabangi and Kipp, 2007). In public health facilities, it was alleged that health staff sale medical supplies (contraceptives) that are meant to be free patients. And more than 65% of user charges for services are embezzled (Bouchard et al, 2012). Teenagers in Uganda face obstacles in accessing and utilizing services that could prevent teenage pregnancy.

3.4.6 Social media

Use of social media as a positive technological advancement has in turn increased risky sexual behavior among adolescents in Uganda. Teenagers use their phones for watching pornography, and share, receive or send information that is sexually enticing, and parents are unable to monitor them (Bantebya et al, 2014). As reported in a study to explore sexual knowledge and behavior among adolescents in south western Uganda by Kemigisha et al *(*2018), eight-five percent of adolescents got information on sexual and reproductive health from media of which thirty five of them contacted media with sexual content. This is further confirmed by Nagaddya et al, (2017) in a study to access influence of social networking on adolescent behavior who reported that 68.9% of adolescents thought that pornographic posts, or videos and pictures changed their behavior towards sex as some of them after watching actually looked for someone to have sexual intercourse with consequently exposing them to unplanned pregnancy. Wado, Sully and Mumah, (2019) in a study to analyze risks and protective factors for adolescent pregnancy in east Africa, also highlighted social media exposure as a cause of teenage pregnancy. Use of cell phones was also identified as a factor that influenced adolescent pregnancies in South Africa (Yakubu Ibrahim and Jawula, 2018). However, media can also be an important source of information as noted in a study which reported that friends and media provided information on use of emergency contraceptives to prevent unwanted pregnancy (Kipp, 2007).

3.4.7 Religion

Religion has influence and goes hand in hand with sexuality and sexual wellbeing (Arousell and Carlbom, 2016, Rutaremwa (2013), in a study to identify factors for teenage pregnancy and early childbirth in Uganda found out that the highest number of young

mothers and those who were pregnant were Muslims followed by Catholics and then Protestants at 29%, 24% and 22% respectively. In a Northwest Uganda, it was pointed out that unlike socio-economic issues, religious and cultural factors affect behavior and outcomes and places girls in situations of vulnerability (Kiapi-iwa and Hart, 2004). Religion creates an ideology and cultural force that strongly directs attitudes of people (Adamczyk and Hayes, 2012). This is also true in a literature review study of economic impacts of child marriage where in South Africa, religion and early marriage were factors that contributed to teenage pregnancy. Socio-cultural norms constructed by religion dictates on and puts them at a disadvantage to education, decent employment and on when a girl gets married (Parsons et al, 2015). However, Muslims were found to use more contraceptives than Catholics in a study by (Kabagenyi, Habaasa and Rutaremwa, 2017). Nakiboneka and Maniple (2008) reported that Catholics condemn contraception in their teachings and to them, children are a blessing from God citing biblical verse form Genesis 1:28 which say *".. be fruitful and multiply.."* besides for them, sexual intercourse is only for the married couples.

3.5 Effective strategies within Uganda and other countries to address teenage pregnancy

The WHO guidelines (2011) on preventing early pregnancy and poor reproductive outcomes in developing countries recommends actions and research on; preventing child marriage and preventing poor reproductive health outcomes. This section provides strategies that have been found to have succeeded in preventing teenage pregnancy both within and outside Uganda.

3.5.1 Sexuality Education programs

During the ICPD, governments were called upon to provide young people with CSE. However, its implementation has been affected in countries with the HIV epidemic because young people were only educated on abstinence from sex (Haberland and Rogow, 2015). Yet programs that emphasize abstinence only has been proven not to delay sexual encounter as compared to CSE that indicated better sexual behaviors and contraceptive use (Kirby D, 2008). Countries like Uganda, a low-income country with high fertility rate requires CSE urgently for her adolescents who contribute to over fifty percent of her population (Annex). However, many obstacles to implementation have been identified (Vanwesenbeeck et al, 2016). Also, CSE taught lacks important information about contraception, sexual intercourse, sexual health and teachers not being adequately knowledgeable or they felt the topic was so delicate to handle (Chandra-Mouli, 2018). Due to the controversies about CSE by legislators and leaders in Uganda, CSE was banned in 2016. In 2018, the MoES approved Sexuality Education framework to be taught in schools but implementation has been halted because of content issues and questions that need to be answered like children out of school and those in hard to reach areas with no schools that would miss the opportunity to receive CSE (Idha, 2017). Kenya introduced CSE and a study in 2015 and during evaluation, over 90% of students considered CSE as very important in their lives, majority wanted more time allocated to learning about sexuality related topics (Sidze et al, 2017). If sexual and reproductive health education is given at the same time with counselling and contraceptive services, then more knowledge on sexual health and contraceptive use will improve, and teenage pregnancy will be reduced (Salam et al, 2016).

Evaluation of programs helps understand impact of a program and clear efforts to address challenges will be sought. One program that was evaluated and found to be a success and

expanded to Africa and beyond was, The World Starts With Me (WSWM). It was a computer based CSE programme started in Uganda in 2003 and implemented by School Net Uganda (SNU). This programme was carried out among students of 12 to 19 years with an aim of providing interactive programmes on SRHR and programs that improve socio-economic status of the adolescents. Teachers were trained as facilitators and peer educators as source of knowledge. The main message was love and sexuality as origins of life (Rutgers, 2016). A mixed model evaluation study that was repeated to find out how effective the program was as regards socio-cognitive determinants of safe sex behavior after the test and it showed improvements in what adolescents thought and believed prevented pregnancy, the way they judged condom use was better and they dealt with sexual violence better (Rijsdijk et al., 2011).

Another reason why girls dropped out of school and got exposed to risky sexual behaviors that lead to teenage pregnancy is menstruation challenges and lack of financial incentives. So, Ministry of Education and Sports launched a National strategy to address challenges on education of girls. To address this, **Empowering Girls to keep at School is an Education Local Expertise Centre (ELECU)** was created in Lango, Teso and Rwenzori sub regions. Here Senior woman teachers are trained to respond to menstrual hygiene needs of girls while at home parents and guardians are also engaged in meetings to address issues around sexuality. However lack of resources was a big setback for this program (Empowering girls to keep at School Local Expertise Centre, 2019).

Other NGOs that have responded to improve education among girls, **BRAC Uganda** through Mastercard Foundation provides scholarships to needy children from Secondary schools (BRAC Uganda, 2017). Other local NGOS like **Prince Of Peace Orphans and Widows (POPOW)** operating in Kaberamaido district in Eastern Uganda work with communities and schools by training girls and women make sanitary pads with locally available materials to address menstruation challenges (Ringe, 2011).

3.5.2 Health services programs

In Uganda, there are few facilities that provide youth friendly services (Kok et al, 2017). According to Rutgers report (2016), only five per cent of government health facilities provide services friendly for young people. If well managed, AFHS can be a success. This clearly shows difficulty young people face in accessing services targeted towards them in Uganda. Eighteen centres that provide services for young people around the world were evaluated and it was discovered that the centres were only accessed and utilized by a small number of young people who lived close by. Those that used the service only came to participate in activities for leisure, many users of the services were older and services were expensive (Chandra-mouli, Lane and Wong,2015). As noted in Malawi during evaluation that even when extra efforts were placed on implementation of the services, majority of people were not aware of the services and only 13% used it. Besides, adolescents questioned quality of services provided. However, in a study to evaluate impact after reorganization of health services, building capacity using adolescents in every stage there was a significant rise in use of services including contraception among adolescents in intervention area as compared to control communities (Denno et al, 2015). In Uganda NGOs contributing to better health outcomes for adolescent include; **Marie Stopes Uganda (MSU),** the single largest known healthcare organization which offers sixty percent of contraceptive services in Uganda. Contraceptive services are offered through 30 outreach sites for women in rural areas, 15 clinics in urban areas, 185 blue star social franchise clinic with a minimal fee and 80 community professional workers and carry out capacity building for health workers in the government facilities in contraceptive services among others. With these, in 2018 alone, 595,105 unwanted pregnancies were prevented, 1,485,756 received contraceptives and 226,693 unsafe abortions were prevented (Marie Stopes Uganda, 2019).

3.5.3 Socio-economic programs Interventions that aimed at improving socio-economic wellbeing of especially teenage girls will prevent teenage pregnancies in Uganda. Uganda has 75.7 percent of her population below 30 years and unemployment rate of 65% among young people (Uganda Bureau of Statistics 2018). The National Development plan of 2010/2011 to 2014/2015 emphasized improvement of non-formal entrepreneur skills to mitigate poverty levels and increase employment. In response to this, was establishment of Youth Livelihood program (YLP) by government in 2013 to empower young people in areas of livelihoods, development of skills, build capacity and increase income (Ministry of Gender, Labour and Social Development 2017). An evaluation study was done in Gulu and Oyam districts in northern Uganda and revealed that the program was generally effective but lack of funds was cited as an hindrance to monitor and supervise the project by the district team was a setback to the program (Ejang et al, 2018). Ministry of Gender, Labour and Social Development (2017) also reported inadequate funds, technical incapacity for some districts, internal conflicts, intended violation of guidelines, unexpected disasters and negative attitude of some young people as challenges to implementation of the YLP.

NGOs have also contributed to addressing teenage pregnancy and improvement of livelihood among young people in Uganda;
BRAC Uganda with the Empowerment and Livelihood for Adolescents (ELA) program is the largest youth empowerment platform in Uganda. This program involves formation of "adolescent clubs" and targets girls from 13 to 21 years especially those out of school to empower them attain better socio-economic wellbeing to become change makers in their communities. In the clubs, discussions around sexual and reproductive health, early pregnancies, violence, substance abuse among other take place openly and trainings on income generating skills take place too. Parents, community leaders and guardians are also engaged in meetings to create awareness and help teenage girls. Result showed that 47,215 skills trainings were facilitated in 37 districts of Uganda so far (BRAC Uganda, 2018). Further, evaluation of the ELA project after two years of establishment reported that in the communities which had the ELA project, there was a 4.4% increase in number of adolescent girls that joined the program which was equivalent to 35% increase from the baseline (Bandiera et al., 2012)

3.5.4 Community engagement programs
According to WHO (2011), programs to end teenage and early pregnancy must aim at decreasing marriage before 18 years, improve understanding and support towards reducing pregnancy below twenty years and reduce sexual coercion and building support from communities including male engagement.
Involving men by engaging them in group discussions, campaigns and community mobilization helps narrow the gender inequality gap that exists between men and women. By doing so, women will be respected, their decisions recognized including decisions on their sexuality thereby preventing poor reproductive health outcomes like teenage pregnancy (Svanemyr *et al.*, 2015). In a study to examine perceptions regarding obstacles to men support in uptake of contraception in Bugiri and Mpigi districts of Uganda by Kabagenyi et al, (2014), men were not involved in prevention of unwanted pregnancies because they did not have time and were not aware of their roles in relation to reproductive health.

Some NGOs that are working to improve community engagements and collaboration to improve adolescent health are:
SRHR Alliance which tackles issues concerning adolescents and young people both in and out of school in every region within the country to improve and provide enabling environments for provision of quality services and information for the young people. Young people benefited greatly from information and quality services right to the grassroots

(SRHR Alliance Uganda, 2019). For example, young people advocated for and engaged with major stakeholder which was not the case previously. However, time constraints, financial issues and attention were challenges that made collaboration and coordination difficult. In spite of the hindrances, their presence as partners alone outweighed the challenges faced (Kaleidos Research, 2016).
Reproductive Health Uganda (RHU), is a member of IPPF currently working in 29 districts of Uganda. RHU prioritizes advocacy for rights and gender equality partnering with other CSOs, expanding access and quality of sexuality education and serving people through public and private providers to provide rights based, client focused, gender sensitive and adolescent friendly reproductive health service.

In conclusion, even with the policies and strategic plans established with clear objectives to tackle teenage pregnancies and create enabling environments, the rates of teenage pregnancy are still high and the impact and burden the country is very heavy considering the weak economy and ailing situation especially in the public sector.

Interventions that target factors at all levels including; provision information and services on sexual and reproductive health for teenage girls, improving access to contraception for girls both in and out of school and increasing coverage of adolescent friendly services will address teenage pregnancy in Uganda.

4.0 CHAPTER FOUR

This chapter reflects on the most important factors contributing to teenage pregnancies in Uganda. It identifies critical factors that require multi level and multi-sectoral interventional approach. It further demonstrates how each factor link to one another. Clear interventional strategies to reduce teenage pregnancies have been illustrated in this chapter. It also identifies weak link in data in some of the studies whose articles reviewed and requires further research exploration.

4.1 DISCUSSION

Teenage pregnancy results of interplay of various complex drivers that operate at different levels namely individual, family, community and societal levels. Poverty, transactional and sexual coercion, place of residence and lack of information and knowledge on sexuality and inadequate resources are interlinked.

Household poverty plays a significant role in teenage pregnancy because it denies the girl child access to basic rights like education and reproductive health care supplies. In a country where more than one third of the population live below 1.9 dollars per day and total fertility rate of 5.2 (UBOS, 2018), parents especially those in rural or in families with low income give their young daughters in-marriage in exchange of gifts and small items in form of dowry. Furthermore, poverty forces girls to engage in concurrent sexual relationships which are transactional in nature where teenage girls exchange sex for money thereby compromising their negotiation power for safer sex (Nalukwago *et al.*, 2018; Tuyiragize et al., 2018). In some cases pregnancy is a perceived means of sustained financial support from the partner as reported by (Kyokwijuka, 2009).
The cost of reproductive commodities limits uptake among youth who are largely unemployed. Socio-economic interventions that will improve household incomes and livelihood for teenagers will greatly contribute to reduction and prevention of teenage pregnancies. In Uganda, the YLP was initiated but inadequate monitoring of the programs hindered success in most areas.

Sexual violence and coercion are widespread in Uganda and young women aged 15-19 years are particularly vulnerable. Sexual coercion contributes to early initiation of sexual activity among teenagers. It has been related to gender norms and stereotypes of male dominance and entitlement to sex, low level of education among teenagers and poverty. Sexual violence makes it difficult for a girl to have time to negotiate safe sex further putting them at greater risk of teenage pregnancy (Stoebenau et al, 2016). Much as policies are in place to support gender equality, enforcement of laws against sexual violence remain weak (UNFPA 2013; Kemigisha *et al.*, 2017). Additionally, sexual violence and coercion are deeply rooted in socio- cultural norms that are slow and difficult to change. Community programs that engage all stakeholders including men, boys in addressing teenage pregnancy would yield better outcomes in interventions to address teenage pregnancy.

Findings from this study have highlighted low contraception uptake among teenagers which are attributed to a number of factors such as inadequate knowledge of contraceptive methods, limited access to adolescent friendly health facilities especially in rural settings where majority of the youth in Uganda live and low levels of staffing especially for reproductive services (Neal, Chandra-Mouli and Chou, 2015). Even where health services are available, negative and judgemental attitudes of health personnel about adolescent sexuality and the rights of young people make the health system unfriendly for the teenagers. While various policies were established to specifically protect, promote and improve SRHR of teenagers, implementation of Adolescent friendly services has been weak in Uganda because the interventions are largely donor driven hence not scaled up and sustainable. In addition, impact assessment of these interventions was minimal.

The study also revealed that level of education affect teenage pregnancy, Adolescent girls who drop out of school or did not have any school education are more susceptible to pregnancy (50%) than school going girls (20%) primary school (Uganda Bureau of Statistics, 2018). This could be due to schools being venues for delivery of sexuality related information such as dangers of risky sexual behaviors and practices like early marriages. In addition, teenagers out of school miss out on the opportunity to be able to clearly read and understand important sexuality information that is more readily available in schools (Batwala, 2006). The introduction of free universal primary and secondary education programs in Uganda was aimed at keeping adolescents in school as a means of reducing teenage pregnancies among other things. However, evaluation of the programs has not shown their effectiveness in reducing school dropout among girls especially.

Sexuality education offers a primary preventive approach for adolescent sexual risk factors such as teenage pregnancy if taught both in and out of school. However, is implementation remains weak in Uganda due to controversies on content, inadequacies of teachers and parents in discussing issues of sexuality with their adolescents and limited resources coupled with emphasis placed on abstinence approach (Råssjö and Kiwanuka, 2010). Involvement of stakeholders particularly parents and teachers early in the design of the CSE intervention and exhibiting cultural sensitivity in a community where it had hitherto been a taboo for adults and pupils to discuss sexual issues (Nair, Paul and Leena, 2012) can enhance its successful integration.

4.1.5 Effective interventions

CSE has been proven to be effective in addressing sexual and reproductive health problems among teenagers including teenage pregnancy. However, in Uganda after the ban of sexuality education in 2016, efforts to reintroduce it have been stopped due to controversies on content.

Adolescent friendly services also provide teenagers with information and services on sexuality. These services are very limited in number with inadequate resources that affects demand and delivery. If CSE are taught both in- and out-of-school and more adolescent friendly centers established and well resourced, it would be a good milestone to addressing teenage pregnancy in Uganda.

Socio-economic interventions that will improve livelihood for teenagers will greatly contribute to reduction and prevention of teenage pregnancies as income level will improve thus a reduction in poverty which is a strong driving force to teenage pregnancy in Uganda. In Uganda the YLP was initiated but inadequate monitoring of the programs hindered success in most areas. Programmes that attempted to empower girls and families with economic support would contribute to uplifting the welfare of citizens. With majority of families living below poverty line, such an activity may first and foremost require equipping them (families) with entrepreneurship to make meanigful impact.

Community programs that engage all stakeholders including men within the communities in addressing teenage pregnancy will yield better outcomes in interventions to address teenage pregnancy.

A combination of all these strategies at national, regional, community and household levels involving multiple stakeholders provide better outcomes in addressing teenage pregnancy in Uganda as single program interventions would not cover all aspects involved around teenagers. Participation of key ministries like: Health, Education, Gender, Labour and Social development to develop joint plans for teenage prevention strategies would go a long way to addressing the problems. This would address multiple factors at a goal.

4.1.6 Conceptual framework used

The Ecological framework used helped answer multilevel factors within which teenage girls get pregnant in context of Uganda. This is because teenage pregnancy is a problem that affects many sectors and strategies for prevention require interventions at all levels. The framework was adopted from a similar study by Svanemyr et al, (2014) which was creating an enabling environment for adolescent sexual and reproductive health services for adolescents.

4.2 CONCLUSION

Teenage pregnancy prevalence remains high in Uganda. Complications of teenage pregnancy and childbirth have contributed to high maternal and child morbidity, mortality further weakening the already constrained economy. This study sought to explore broader factors for the high rates of teenage pregnancy so that strategies can be identified and recommend made for prevention of teenage pregnancy in the context of Uganda.

Factors for teenage pregnancy range from individual, interpersonal relationships, community and society factors. Poverty, transactional and sexual coercion, lack of information and knowledge on sexuality and inadequate resources were significant factors that contributed to teenage pregnancy in Uganda. Provision of CSE, increasing coverage and resourcing of adolescent friendly services, improving social economic status of teenage girls and improving programs for community engagements if done concurrently would ensure better outcomes in the health and wellbeing of teenagers. Multi-sectoral integration will provide environments that are favorable for teenagers and enable them make better informed decisions about their sexuality. More so, involving parents, teachers, religious and community leaders will create awareness on sexuality among teenage girls.

4.3 RECOMMENDATIONS

These recommendations are directed to the MoH and for the MOH to engage with other ministries that directly work to improve wellbeing of teenagers and improve monitoring, evaluation of programs at national, regional, district and community levels.

- We recommend that teenagers should be provided with sexual education for them to learn about the changes they go through and their sexual reproductive health rights.
- Other measures such as promoting household wealth creation and ensuring girls keep in school by providing them with school materials and other school requirements.

- Formulate policy for the provision of adolescent friendly health services at health facilities that include a wide range of options, as well as offering counselling and information could mitigate teenage pregnancy. Create more and resourceful Adolescent Friendly Health Services to improve coverage and quality comprehensive service delivery. Coverage and quality can be achieved by effective resource mobilization and strict accountability and follow up of activities carried out.

- Priority should be given to re-intergrate CSE in the school curriculum. The MoE to begin by engaging stakeholder to iron out pressing concerns, through consensus incorporate in to CSE framework. Through CSE, more information on all issues around sexuality and life skills will be availed to young people to make informed decisions regarding their health.
- Advocate for and liaise with Ministry of Education and other stakeholders to fasten implementation of age appropriate CSE whose policy was launched and awaits implementation right from primary schools.

- Improve partnership and actively coordinate and strengthen stewardship of NGOs and CBOs working to improve health and wellbeing of teenagers. This can be done through following strict monitoring, evaluation of projects implemented.

- Inclusiveness of policy makers, leaders at all levels, teachers and parents and young people as champions at every level of programming from planning, monitoring, implementation and evaluation of projects that target young people.

- Advocate for empowerment of young girls with livelihood programs that should be able to get them out of poverty through Ministry of Gender, Labour and Social affairs.

- More studies need to be taken to evaluate effectiveness of programs that address teenage pregnancy in Uganda. In particular a study to understand what adolescents need in times of sexual and reproductive health and rights.

REFERENCES

Adamczyk, A. and Hayes, B. E. (2012) 'Religion and Sexual Behaviors : Understanding the Inf luence of Islamic Cultures and Religious Affiliation for Explaining Sex Outside of Marriage'. doi: 10.1177/0003122412458672.

Advancing Partners & Communities (2016) *Preventing Unintended and Unplanned Pregnancy among In-school Youth : An Acceptability and Feasibility Assessment*.

Agardh, A., Tumwine, G. and Östergren, P. O. (2011) 'The impact of socio-demographic and religious factors upon sexual behavior among Ugandan university students', *PLoS ONE*, 6(8). doi: 10.1371/journal.pone.0023670.

Andi, J. R. Wamala,R, Ocaya, B, Kabagenyi, A. (2014) 'Europe PMC Funders Group Modern contraceptive use among women in Uganda : An analysis of trend and patterns (1995-2011)', 28(2), pp. 1009–1021. doi: 10.11564/28-0-553.Modern.

Arousell, J. and Carlbom, A. (2016) 'Best Practice & Research Clinical Obstetrics and Gynaecology Culture and religious beliefs in relation to reproductive health', *Best Practice & Research Clinical Obstetrics & Gynaecology*. Elsevier Ltd, 32, pp. 77–87. doi: 10.1016/j.bpobgyn.2015.08.011.

Atuyambe, L. M.Kibira, S, Bukenya, J, Muhumuza, C, Apolot R, Mulogo, E. (2015) 'Understanding sexual and reproductive health needs of adolescents: Evidence from a formative evaluation in Wakiso district, Uganda Adolescent Health', *Reproductive Health*. ???, 12(1), pp. 1–10. doi: 10.1186/s12978-015-0026-7.

Ayalew M, Mengistie B and Semahegn A. (2014) 'Adolescent-parent communication on sexual and reproductive health issues among high school students', *Reproductive Health*, 11(1), p. 77.

Bandiera, O. Buehren, N, Burgress, R, Goldstein, M. (2012) 'Empowering Adolescent Girls : Evidence from a Randomized Control Trial in Uganda ¤'.

Bantebya, G, Ochen, E,Pereznieto, P, Walker, DG. (2014) 'sexual relations in Uganda : Income poverty as a risk factor for adolescents', (December).

Bastien, S., Kajula, L. and Muhwezi, W. (2011) 'A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa', *Reproductive Health*, 8(1), pp. 1–17. doi: 10.1186/1742-4755-8-25.

Batwala, VK, Nuwaha,F, Bajunirwe, F, Mirembe, JB. (2006) 'CONTRACEPTIVE USE AMONG IN AND OUT-OF SCHOOL ADOLESCENTS IN RURAL SOUTHWEST UGANDA Objective : To compare the level of contraceptive use among in and out-of school rural Ugandan adolescents . Design : Cross sectional survey . Setting : Mbarara district . ', 83(1), pp. 18–24.

Boonstra Heather D (2007) 'How Will the World Respond ?', 10(3), pp. 2–8.

Bouchard, M, Orbinski, J, Howard, A. (2012) 'Corruption in the health care sector: A barrier to access of orthopaedic care and medical devices in Uganda', *BMC International Health and Human Rights*. BioMed Central Ltd, 12(1), p. 1. doi: 10.1186/1472-698X-12-5.

BRAC Uganda. (2017) 'UGANDA. Annual Report 2017'.

Bronfenbrenner, Urie, and P. A. (2006) 'The bioecological model of human

development.” Handbook of Child Psychology (2006).’ Available at: https://www.learning-theories.com/bronfenbrenners-bioecological-model-bronfenbrenner.html.

Burns Kimberly (2011) ‘Sexuality education in a girls ’ school in Eastern Uganda Sexuality education in a girls ’ school in Eastern Uganda’, 0950(2002), pp. 81–88.

Byamugisha, J. K., Mirembe, F. M. and Gemzell-danielsson, E. F. K. (2006) ‘Emergency Contraception and Fertility awareness among University Students in Kampala , Uganda’, pp. 194–200.

Cherry Andrew L (2014) ‘Biological Determinants and Influences Affecting Adolescent Pregnancy. In: Cherry A., Dillon M. (eds) International Handbook of Adolescent Pregnancy. Springer, Boston, MA pp 39-53’.

Denno, D. M. *et al.* (2015) ‘Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support’, *Journal of Adolescent Health*. Elsevier Inc., 56(1), pp. S22–S41. doi: 10.1016/j.jadohealth.2014.09.012.

Dr V Chandra-Mouli (2018) ‘Comprehensive Sexuality Education’, (July), pp. 1–11.

Ejang, M. *et al.* (2018) ‘EFFECTIVENESS OF THE YOUTH LIVELIHOOD PROGRAMME IN REDUCING YOUTH UNEMPLOYMENT: THE CASE OF GULU AND OYAM’, 30, pp. 1–33.

AKanbi, F., Afolabi KK and Aremu, AB, A. (2016) ‘Primary Health Care : Open Access Individual Risk Factors Contributing to the Prevalence of Teenage Pregnancy among Teenagers at Naguru Teenage Centre Kampala , Uganda’, 6(4). doi: 10.4172/2167-1079.1000249.

Kyoheirwe Muhanguzi (2011) Gender and sexual vulnerability of young women in Africa: experiences of young girls in secondary schools in Uganda, Culture, Health & Sexuality’,.

Green C, M. A. and Rubin, D. Mukuria, A. (2009) ‘Addressing Early Marriage in Uganda - Cultural Practice : Cultural Practice’, (March). Available at: http://www.culturalpractice.com/resources/addressing-early-marriage-in-uganda/.

Guttmacher (2013) ‘Unintended Pregnancy and Abortion in Uganda’, (2), pp. 1–8.

Guttmacher Institute (2017) ‘Contraception and Unintended Pregnancy in Uganda’, (February).

Haberland, N. and Rogow, D. (2015) ‘Sexuality education: Emerging trends in evidence and practice’, *Journal of Adolescent Health*. Elsevier Inc., 56(1), pp. S15–S21. doi: 10.1016/j.jadohealth.2014.08.013.

Ministry of Health. (2010) ‘National Health Policy ll’, *Public Health*, 32, p. 6. doi: 10.1016/s0033-3506(18)80155-x.

Ministry of Health. (2010) ‘Health Sector strategic and Investment Plan 210/11-2014/15’, (July).

Ministry of Health. (2015) ‘The National Adolescent Health Strategy 2011-2015’.

HEPS Uganda (2013) ‘Women ’ s health and sexual and reproductive health in Uganda : A review of evidence’, (March), pp. 0–15.

Idha Filbert A (2017) 'who will teach out of school by 2017?. The New Vision Newspaper 27th October 2017'.

International centre for research on women Forum for African Women Educationalists Uganda (2014) " *I wanted to study with all my Heart. Unpacking Reasons for Girls' School Drop-out in West Nile, Uganda*.

Jennifer Parsons, Jeffrey Edmeades, Aslihan Kes, Suzanne Petroni, M. S. & Q. W. (2015) (2015) 'Economic Impacts of Child Marriage: A Review of the Literature', *The Review of Faith & International Affairs*. Taylor & Francis, 13(3,), pp. 12–22. doi: 10.1080/15570274.2015.1075757.

João Casqueira C and Mwolo Martha (2017) 'Assessment of non-formal sexual education strategies for adolescent girls : the case of Tanzania 1', pp. 527–547.

Getachew Mullu, K, Arowojolu, A, Odukogbe, A, Alemayhu. (2018) 'Prevalence and determinants of adolescent pregnancy in Africa : a systematic review and Meta-analysis'. Reproductive Health, pp. 1–17.

Kabagenyi, A, Larissa, J, Reid, A, Ntozi, J, Atuyambe, L. (2014) 'Barriers to male involvement in contraceptive uptake and reproductive health services : a qualitative study of men and women ' s perceptions in two rural districts in Uganda', pp. 1–9.

Kabagenyi, A., Habaasa, G. and Rutaremwa, G. (2017) 'Europe PMC Funders Group Low Contraceptive Use among Young Females in Uganda : Does Birth History and Age at Birth have an Influence ? Analysis of 2011 Demographic and Health Survey', 1(1), pp. 1–12.

Kaleidos Research, ICRH. (2016) 'UNITE FOR BODY RIGHTS – SRHR ALLIANCE', (March).

Kemigisha, E. (2018) 'Sexual health of very young adolescents in South Western Uganda : a cross-sectional assessment of sexual knowledge and behavior'. Reproductive Health, pp. 1–8.

Kemigisha, E. Nyakato, v, Bruce, K, Ndaruhutye, R, Coene, G, Micheilsen, K, Ninsiima, A, Wendo, M. (2018) 'Adolescents ' Sexual Wellbeing in Southwestern Uganda : A Cross-Sectional Assessment of Body Image , Self-Esteem and Gender Equitable Norms'. doi: 10.3390/ijerph15020372.

Kiapi-iwa, L. and Hart, G. J. (2004) 'The sexual and reproductive health of young people in Adjumani district, Uganda: qualitative study of the role of formKiapi-iwa, L. and Hart, G. J. (2004) 'The sexual and reproductive health of young people in Adjumani district, Uganda: qualitative study ', *AIDS Care*. Taylor & Francis, 16(3), pp. 339–347. doi: 10.1080/09540120410001665349.

Kipp, N. w; B. and (2007) 'Emergency Contraception among young people in Uaganda. User and provider perspectives'.

Kirby Douglas (2008) 'The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior'.

Kirk, J. and Sommer, M. (2004) 'Menstruation and body awareness : linking girls ' health with girls ' education', pp. 1–22.

Klepp, K, Flisher, A,Kaya, SF. (2008) *Promoting Adolescent Sexual and Reproductive Health in East and Southern Africa Edited by*.

Kok Maryse, K. B. and de Vries Irene, K. tasneem (2016) '" Get Up Speak Out " baseline

report Uganda', pp. 1–76.

Kyokwijuka Besigiroha Gad Moses (2009) 'Risk Factors of Adolescent Pregnancy in Kabale District - Uganda A Dissertation Submitted in Partial Fulfillment of the Requirements for the award of the Degree of Master of Science December 2009', (December).

Empowering girls to keep at School Local Expertise Centre. (2019) 'Strategic Plan', pp. 2015–2019.

Leerlooijer Joanne *et al.* (2013) 'Qualitative evaluation of the Teenage Mothers Project in Uganda : a community-based empowerment intervention for unmarried teenage mothers', pp. 1–15.

Empowering girls to keep at School Local Expertise Centre. (2019) 'Strategic Plan', pp. 2015–2019.

Lule Herman, Ovuga E. Mshilla M, Ojara S, Kimbugwe G, Adrawa AP, M. n (2013) 'Knowledge, Perceptions and Acceptability to Strengthening Adolescents' Sexual and Reproductive Health Education amongst Secondary Schools in Gulu District', 7(7), pp. 1787–1802.

Madanda, A. and (2011) *A Survey on Re-entry of Pregnant girls in Primary and secondary Schools in Uganda*. doi: 10.1084/jem.186.11.1897.

Makate Marshall and Makate Clifford (2018) 'Education and teenage childbirth in Uganda Understanding the links from the Uganda Demographic and Health Survey'. doi: 10.1108/IJSE-03-2017-0077.

Maly, C.Catherine, A, Baumgatner . (2017) 'Perceptions of Adolescent Pregnancy Among Teenage Girls in Rakai , Uganda'. doi: 10.1177/2333393617720555.

Mariestopes Uganda (2019) 'MSU.What we do'.

Markham, C. M. *et al.* (2010) 'Connectedness as a Predictor of Sexual and Reproductive Health Outcomes for Youth Connectedness as a Predictor of Sexual and Reproductive Health Outcomes for Youth', (March). doi: 10.1016/j.jadohealth.2009.11.214.

di Mauro, D. & Joffe, C. (2007) *The religious right and the reshaping of sexual policy: An examination of reproductive rights and sexuality education*. doi: doi.org/10.1525/srsp.2007.4.1.67.

Mehra, D. *et al.* (2012) 'Non-use of contraception: determinants among Ugandan university students', 9716. doi: 10.3402/gha.v5i0.18599.

Ministry of Education and sports (2017) 'Education and Sports Strategic plan 2017/18-2019/20', (September 2017).

MINISTRY OF GENDER, Labour and Social Development. (2017) 'YOUTH LIVELIHOOD PROGRAMME : ECONOMIC EMPOWERMENT FOR PEACE BUILDING AMONG THE YOUTH IN UGANDA'.

Ministry of Health. (2011) 'UGANDA HEALTH SYSTEM ASSESSMENT 2011'.

Ministry of Health. (2012) *Adolescent Health Policy Guidelines and Service Standards*.

Mukasa, N. (2014) 'Uganda Healthcare system profile : Background , Organization ,

Polices and Challenges Issue 1 . Volume 1', (July).

Nabukeera Madinah (2016) 'Challenges and Barriers to the Health Service Delivery System in Uganda', 5(2), pp. 30–38. doi: 10.9790/1959-0502053038.

Nagaddya, R. *et al.* (2017) 'Assessing the Influence of Social Networking Material on Adolescents ' Sexual Behavior in Kampala', 8(15), pp. 187–193.

Nair, M. K. C., Paul, M. K. and Leena, M. L. (2012) 'Effectiveness of a Reproductive Sexual Health Education Package among School Going Adolescents', 79(January), pp. 64–68. doi: 10.1007/s12098-011-0433-x.

Nakiboneka, C. and Maniple, E. (2008) 'FACTORS RELATED TO THE UPTAKE OF NATURAL FAMILY PLANNING BY CLIENTS OF CATHOLIC HEALTH UNITS IN MASAKA DIOCESE , UGANDA', 6(3), pp. 126–141.

Nalukwago, J. *et al.* (2018) 'Application of Core Processes for Understanding Multiple Concurrent Sexual Partnerships Among Adolescents in Uganda', 6(December), pp. 1–13. doi: 10.3389/fpubh.2018.00371.

Nalwadda, G. *et al.* (2010) 'Persistent high fertility in Uganda : young people recount obstacles and enabling factors to use of contraceptives'.

Nalwadda, G. *et al.* (2011) 'Constraints and prospects for contraceptive service provision to young people in Uganda : providers ' perspectives'. BioMed Central Ltd.

Neal, S, Wong, E, Chandra-Mouli, V. and Chou, D. (2015) 'Adolescent first births in East Africa: Disaggregating characteristics, trends and determinants Adolescent Health', *Reproductive Health*, 12(1), pp. 1–13. doi: 10.1186/1742-4755-12-13.
Venkatraman, Chandra-mouli

Silvia, Lane Catherine and Wong

Ninsiima, A. B. *et al.* (2017) '" Girls Have More Challenges ; They Need to Be Locked Up ": A Qualitative Study of Gender Norms and the Sexuality of Young Adolescents in Uganda'. doi: 10.3390/ijerph15020193.

Ochen, A. M., Chi, P. C. and Lawoko, S. (2019) 'Predictors of teenage pregnancy among girls aged 13 – 19 years in Uganda : a community based case-control study'. BMC Pregnancy and Childbirth, pp. 1–14.

Odimegwu, C. and Mkwananzi, S. (2016) 'Factors Associated with Teen Pregnancy in sub-Saharan Africa : A Multi-Country Cross-Sectional Study', 2016(September), pp. 94–107.

OGORI A. F . Ajeya SHiTU fatima and YUNUSA (2013) 'THE CAUSE AND EFFECT OF TEENAGE PREGNANCY : CASE OF KONTAGORA LOCAL GOVERNMENT AREA IN NIGER STATE , NORTHERN PART OF NIGERIA', 1(7), pp. 1–15.

Ringe, F. (2011) 'Developing a Supportive Environment for Children and Youth through Livelihood Development', 880.

Råssjö, E.-B. and Kiwanuka, R. (2010) 'Views on social and cultural influence on sexuality and sexual health in groups of Ugandan adolescents', *Sexual & Reproductive Healthcare*. Elsevier, 1(4), pp. 157–162. doi: 10.1016/J.SRHC.2010.08.003.

Renzaho, A. M. N. *et al.* (2017) 'Sexual , Reproductive Health Renzaho, A. M. N. et al.

(2017) "Sexual , Reproductive Health Needs , and Rights of Young People in Slum Areas of Kampala , Uganda : A Cross Sectional Study", pp. 1–21. doi: 10.1371/journal.pone.0169721.Needs , and Rights of Y', pp. 1–21. doi: 10.1371/journal.pone.0169721.

'World Population Review, Uganda'(2019). **worldpopulationreview**.com/countries/**uganda-population**

Rijsdijk, L. E. *et al.* (2011) 'The World Starts With Me : A multilevel evaluation of a comprehensive sex education programme targeting adolescents in Uganda'.

Rijsdijk, L. E. (no date) 'The World Starts With Me'.

Rukundo, G. Z. *et al.* (2015) 'Antenatal services for pregnant teenagers in Mbarara Municipality , Southwestern Uganda : health workers and community leaders ' views'. BMC Pregnancy and Childbirth, pp. 1–5. doi: 10.1186/s12884-015-0772-0.

Rutaremwa (2013) 'Factors Associated with Adolescent Pregnancy and Fertility in Uganda : Analysis of the 2011 Demographic and Health Survey Data', 3(2), pp. 30–35. doi: 10.5923/j.sociology.20130302.03.

Rutgers (2016) *The World Starts With Me : A successful CSE programme for in- and out-of-school youth in Africa and Asia*.

Salam, R. A. *et al.* (2016) 'Improving Adolescent Sexual and Reproductive Health : A Systematic Review of Potential Interventions', 59. doi: 10.1016/j.jadohealth.2016.05.022.

Sekiwunga, R. and Whyte, S. R. (2009) 'Poor Parenting : Teenagers ' Pregnancies in Eastern Uganda Views on Adolescent', 13(4), pp. 113–127.

Sidze, E. M. *et al.* (2017) 'From Paper to Practice : Sexuality Education Policies and Their Implementation in Kenya', (April).

Stoebenau, K. *et al.* (2016) 'Revisiting the understanding of "transactional sex" in sub-Saharan Africa: A review and synthesis of the literature', *Social Science and Medicine*. Elsevier Ltd, 168, pp. 186–197. doi: 10.1016/j.socscimed.2016.09.023.

Studies, I. of D. (2019) 'Social, economic and political context in Uganda. Empowering women and girls.'

Svanemyr, J. *et al.* (2014) 'Creating an Enabling Environment for Adolescent Sexual and Reproductive Health : A Framework and Promising Approaches', *Journal of Adolescent Health*. Elsevier Inc., 56(1), pp. S7–S14. doi: 10.1016/j.jadohealth.2014.09.011.

Svanemyr, J. *et al.* (2015) 'Creating an Enabling Environment for Adolescent Sexual and Reproductive Health : A Framework and Promising Approaches', *Journal of Adolescent Health*. Elsevier Inc., 56(1), pp. S7–S14. doi: 10.1016/j.jadohealth.2014.09.011.

Tsoaledi, T. D. (2015) 'Factors Contributing to Teenage Pregnancy in South Africa: The Case of Matjitjileng Village', *J Sociology Soc Anth*, 6(2), pp. 273–277. Available at: http://www.krepublishers.com/02-Journals/JSSA/JSSA-06-0-000-15-Web/JSSA-06-2-000-15-Abst-PDF/JSSA-6-2-273-107-15-Thobejane-T-D/JSSA-6-2-273-107-15-Thobejane-T-D-Tx[12].pdf.

Tusiime, S. *et al.* (2015) 'Prevalence of sexual coercion and its association with unwanted pregnancies among young pregnant females in Kampala , Uganda : a facility

based cross-sectional study'. BMC Women's Health, pp. 1–12. doi: 10.1186/s12905-015-0235-9.

UBOS and ICF: 2017. and ICF (2017) 'Uganda 2016 Demographic and Health Survey: Key Findings'. Available at: https://dhsprogram.com/pubs/pdf/SR241/SR241.pdf.

Uganda AIDS Commission (2016) 'THE UGANDA HIV AND AIDS COUNTRY PROGRESS REPORT', (JUNE).

Uganda Bureau of Statistics (2018) 'GOVERNMENT OF UGANDA Uganda Demographic and Health Survey 2016'. Available at: www.DHSprogram.com.

Uganda Bureau of Statistics and Macro International Inc. 2007. (2006) 'Uganda Demographic and Health Survey 2006. Kampala, Uganda and Calverton, Maryland, USA: Uganda Bureau of Statistics and Macro International Inc.'

Uganda, M. of H. (2017) 'Adolescent Health Risk Behaviors in Uganda : A National Cross Sectional Study Final Study Report September 2017', (September).

'SRHR Alliance Uganda'(2019). Overview

UNAIDS (2018) 'Global HIV and AIDS Statistics. Global Information and Educationon HIV and AIDS.'

UNICEF (2009) *THE STATE OF THE WORLD ' S CHILDREN 2009 Maternal and*.

UNICEF (2015a) *Ending Child Marriage and Teenage Pregnancy in Uganda.A FormAtive reseArch to Guide the implementation of the national strategy on ending child marriage and teenage pregnancy in uganda*.

UNICEF (2015b) *THE NATIONAL STRATEGY TO END CHILD MARRIAGE AND TEENAGE PREGNANCY 2014/2015 – 2019/2020*.

UNICEF (2018) 'Uganda: Political Economy Analysis'.

United Nations Population Fund (2013) *ADOLESCENT PREGNANCY : A Review of the Evidence ADOLESCENT PREGNANCY : A Review of the Evidence*.

Vanwesenbeeck, I. *et al.* (2016) 'Lessons learned from a decade implementing Comprehensive Sexuality Education in resource poor settings : The World Starts With Me Lessons learned from a decade implementing Comprehensive', *Sex Education*. Routledge, 1811, pp. 1–15. doi: 10.1080/14681811.2015.1111203.

Venkatraman, C. and Silvia, L. C. and W. (2015) 'What Does Not Work in Adolescent Sexual and Reproductive Health : A Review of Evidence on Interventions Commonly Accepted as Best Practices', 3(3), pp. 333–340.

Wado, Y. D., Sully, E. A. and Mumah, J. N. (2019) 'Pregnancy and early motherhood among adolescents in five East African countries : a multi-level analysis of risk and protective factors'. BMC Pregnancy and Childbirth, pp. 1–11.

Wagman J, Baumgartner JN, Waszak G, Nakyanjo. N, Ddaaki GW, Serwadda, D, Gray. R, Kakaire. F, Nalugoda M, W. J. (2008) 'Experiences of Sexual Coercion Among Adolescent women: Qualitative Findings'.

Wall-Wieler, E., Roos, L. L. and Nickel, N. C. (2016) 'Teenage pregnancy: The impact of maternal adolescent childbearing and older sister's teenage pregnancy on a younger

sister', *BMC Pregnancy and Childbirth*. BMC Pregnancy and Childbirth, 16(1), pp. 1–12. doi: 10.1186/s12884-016-0911-2.

WHO (2011) 'Preventing Early Pregnancy and Poor Reproductive Outcomes'https://apps.who.int/iris/bitstream/handle/10665/70813/WHO.

World Bank (2018) 'The World Bank in Uganda. Overview'.

World Health Organization (2015) 'Trends in Maternal Mortality : 1990 to 2015'. http//:apps.who.int

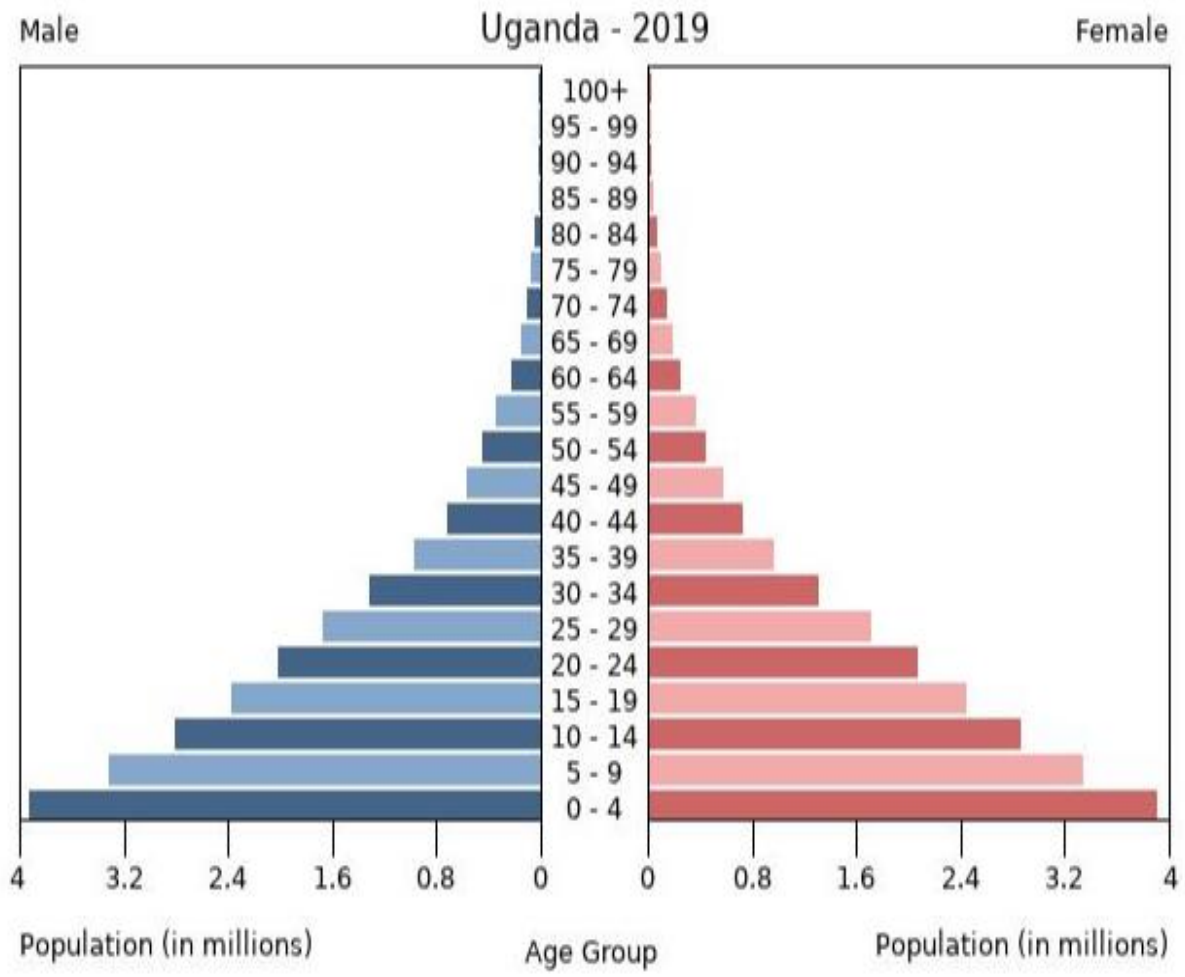
World Health Organization (2017) 'UGANDA POPULATION-BASED HIV IMPACT ASSESSMENT', (August), pp. 62–65.

Yakubu Ibrahim and Jawula, S. (2018) 'Determinants of adolescent pregnancy in sub-Saharan Africa : a systematic review'. Reproductive Health. doi: 10.1186/s12978-018-0460-4.

APPENDIX 1
Fig 1: Map of Uganda showing regions and Districts

Source : (Uganda Bureau of Statistics, 2018)

APPENDIX 2: Population Pyramid of Uganda



Source: (United states Census Bureau,2018)