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Factors contributing to high teenage pregnancy among teenagers aged 15-19 years at Kawaala health center IV, Kampala district. A cross-sectional study.

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Abstract

Background.

Teenage pregnancy countrywide is growing rapidly among school-going pupils, and it leads to teenagers dropping out of school to care for their babies. This study determined the factors contributing to high teenage pregnancies among teenagers aged 15-19 years attending Kawaala Health Centre IV.

Methodology.

The study was a descriptive cross-sectional study by design, and it employed quantitative data collection methods. A simple random sampling method was used to select 30 pregnant mothers for the study. A questionnaire was used to collect data that was analyzed manually, and the results were presented in the form of tables, graphs, and pie charts.

Results.

(60%) Of the respondents were aged 17-19 years, (53.3%) had a primary level of education, and (40%) were married. The cultural factors identified were (66.7%) lack of parental guidance, (70%) peer pressure, (63.3%) sexual harassment and (60%) myths and misconceptions, socio-economic factors identified were (66.7%) poverty, (86.7%) lack of access to the health facility and (20%) misuse of media, individual factors identified were lack of knowledge about contraception (60%) and peer pressure (40%).

Conclusion.

The established factors were: Lack of knowledge about contraception, peer pressure, sexual harassment, myths and misconceptions, poverty, lack of access to the health facility, misuse of media, and lack of parental guidance.

Recommendation.

Ministries should establish an approach that is more holistic to equip the teenagers with appropriate knowledge on sexuality and access to sexual and reproductive health services, rather than traditional coaching approaches that focus on improving sexual ability, attitudes, and norms.

Keywords: *Teenage pregnancy, Adolescents aged 15-19 years, Kawaala Health Center, Kampala district.*
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Background.

According to the United Nations Children Fund (UNICEF), a teenage pregnancy is defined as a pregnancy in girls between the ages of 13 and 19 (Panda et al., 2023). It is a public concern in both the developed and developing world. Globally, 15 million women under the age of 20 give birth each year, and in the developing world, over 3 million women under the age of 20 die due to pregnancy-related complications. The risk of death due to pregnancy-related causes is doubled among women aged 15 to 19. Young women are also at risk of unwanted pregnancies, sexually transmitted diseases, and unsatisfactory or coerced early relationships (Kyegombe et al., 2020). In India, early childbearing particularly has negative demographic, socio-economic, and socio-cultural consequences, which include higher rates of morbidity and mortality for both the mother and infant during and after delivery, with neonatal mortality being 41 per 1000 live births (Scott et al., 2021).

Studies done in African countries showed that early sexual activities increase the risk of multiple sex partners, unprotected sex that leads to sexually transmitted diseases such as AIDS, and risks of premature rupture of membranes, preterm labor, and postpartum infection (Ferede et al., 2023). In sub-Saharan Africa, women get married much earlier than elsewhere, leading to early-age pregnancies. In Nigeria, according to the Health and Demographic Survey in 2018, 47% of women aged 20–24 were married before

15, and 87% before 18. 53% of those surveyed had also given birth to a child before the age of 19.

East Africa has been rated second globally after West Africa as the region with the highest number of women reporting a birth before the age of 19. Uganda leads the region in the number of teenage pregnancies at 33 per cent, followed by Tanzania (28 per cent) and Kenya (26 per cent). At least 5% of young women below the age of 18 in the region are already mothers, while 4% of girls below the age of 15 have children (Kakal et al., 2022). In Uganda, there's a high prevalence of teenage pregnancy, especially in Wakiso district, because young people become sexually active before reaching marriage, and due to a lack of adequate knowledge on sexual and reproductive health. Teenage pregnancy thus remains a burden to both the community and government of Uganda, especially in terms of expenditure, in an attempt to curb the detrimental effects of teenage pregnancy on the lives of teenagers. The Eastern and East-central regions showed the highest rates of teenage pregnancy in Uganda, with 30.1% and 31.6% respectively, which is higher than their surrounding regions like Karamoja and West Nile (Manzi et al., n.d.). This study determined the factors contributing to high teenage pregnancies among teenagers aged 15-19 years attending Kawaala Health Centre IV.

Methodology.

Study design and rationale.

The descriptive cross-sectional design enabled her to describe factors contributing to high teenage pregnancies. Quantitative methods of data collection were employed. Quantitative data collection involved the use of numerical values to assess information. The entire design was chosen because it enabled the researcher to obtain data at one point in time.

Study setting and rationale.

The study was carried out at Kawaala Health Centre IV. Kawaala Health Centre IV is found in the Central region of Uganda, a government-owned hospital under Kampala Capital City Authority (KCCA) with a bed capacity of 72 and above. The facility is located in Kawaala village, Kampala District, on the Kawaala – Kasubi Road, about 15 Kilometers from the city and about 10 kilometers from Kawempe regional referral hospital. The facility provides many health services for both outpatient and inpatient services. The setting was good for the study since it had several required participants with desired qualities the researcher was looking for, and it was easily accessible to the researcher.

Study population.

The study population consisted of all pregnant women attending Kawaala Health Centre IV for maternal and child health services.

Sample size determination.

The sample size was determined according to UNMEB guidelines 2009, which states that the appropriate sample size should be not less than 30 respondents. Therefore, the study targeted 30 respondents. This was manageable due to the limited time and resources for data collection.

Sampling procedure.

A random simple sampling technique was employed. This technique was chosen for this study because it ensured that the sample was a representative of the study population, as well as reducing bias in the sample. This made it possible for the researcher to obtain inferential statistics. The process involved the researcher cutting 60 pieces of similar size and 30 written YES on and the rest. Eligible teenagers picked a single paper at random. Those who picked papers with the word YES took part in the study; 6 respondents were interviewed every day of data collection, and it took a period of 5 days.

Inclusion criteria.

The study included teenagers aged 15-19 years who are pregnant, attending the Kawaala Health Centre IV, maternal and child health services.

Independent variable.

There were factors contributing to high teenage pregnancies.

Dependent variable.

This was a high teenage pregnancies.

Research instruments.

The data was collected from the respondents using a questionnaire with open and closed-ended questions in the English language, which was used as a tool for gathering information. This was preferred in this study because a lot of information was collected over a short period of time.

Data collection procedures.

Data collection helped the investigator obtain information from participants to answer the problem of interest. A guided questionnaire for data collection was used for all participants. The period of data collection was scheduled for 5 days, and the participants were met at the antenatal care clinic, and they were requested to

consent to the study participation. The prepared questionnaire was filled out by the researcher, and the completed questionnaires were collected for data entry and analysis. Thereafter, all answered and entered questionnaires were stored in a secure area.

Data management.

After the collection of data, every questionnaire was checked for completeness, and any gaps were filled immediately before the client was discharged. The questionnaire was kept privately under lock and key, only accessible to the researcher and the research assistant on request, and then it was directly entered into the computer using Microsoft Word and Microsoft Excel 2010 version for coding, validation, and analysis.

Data analysis

Quantitative data were manually tallied according to the variables and were later fed into the computer using Microsoft Excel. Quantitative data was analyzed using Microsoft Word and Excel programs. The analyzed data were presented in the form of frequency tables, figures, graphs, and charts. Frequency and percentage were used for the interpretation and establishment of the relationship between variables.

Ethical considerations

An introductory letter was obtained, allowing the researcher to seek permission to carry out the study. This letter was taken to Kisenyi Health Centre IV to seek permission to pretest the questionnaire, and this same letter was taken to Kawaala Health Centre IV management for approval and to allow data collection. The participants were assured of proper confidentiality and were given numbers each for easy analysis. The study began after the participants understood the objectives of the study and had freely consented.

Informed consent.

Participants received full disclosure of the nature of the study, the risks, benefits, and alternatives, with an extended opportunity to ask pertinent questions regarding the research. The researcher treated all information provided by participants with maximum confidentiality. This was achieved by assigning respondents codes instead of using the actual names of the respondents, which were known to other people. Honesty was maintained throughout the research process; in reporting data, results, methods, and procedures, in order to avoid fabrication, falsification, or misrepresentation of data.

RESULTS

Socio-demographic characteristics of respondents

Table 1: Socio-Demographic characteristics of participants (N=30)

Variables	Categories	Frequencies (f)	Percentage (%)
Age			
	10- 13 years	2	6.7
	14-16 years	10	33.3
	17-19 years	18	60
	Total	**30**	**100**
Level of education			
	None	2	6.7
	Primary	16	53.3
	O'level	9	30
	A' level	3	10
	Total	**30**	**100**
Marital status			
	Single	10	33.3
	Married	12	40
	Divorced	0	0
	Cohabiting	8	26.7
	Total	**30**	**100**
If married, state the circumstances. (n=12)			

	Forced	4	33.3
	Dependency	2	16.7
	Pregnancy	6	50
	Total	**12**	**100**

Table 1: Indicated that the majority, 18(60%) of the respondents were aged 17- 19 years, and the minority, 2(6.7%) of the respondents were aged 10-13 years. Most, 16(53.3%) of the respondents had only attained a primary level of education, while the least, 2(6.7%) had not attended school. A large number, 12(40%) of the respondents were married, and a few, 8(26.7%) of the respondents were cohabiting. Of those who were married, half 6(50%) of them said that they got married because of pregnancy, and the least 2(16.7%) of the respondents reported dependency as their circumstance of getting married.

Individual factors contributing to high teenage pregnancies.

Figure 1: Shows respondents' information on what led them to have sexual intercourse, N = 30

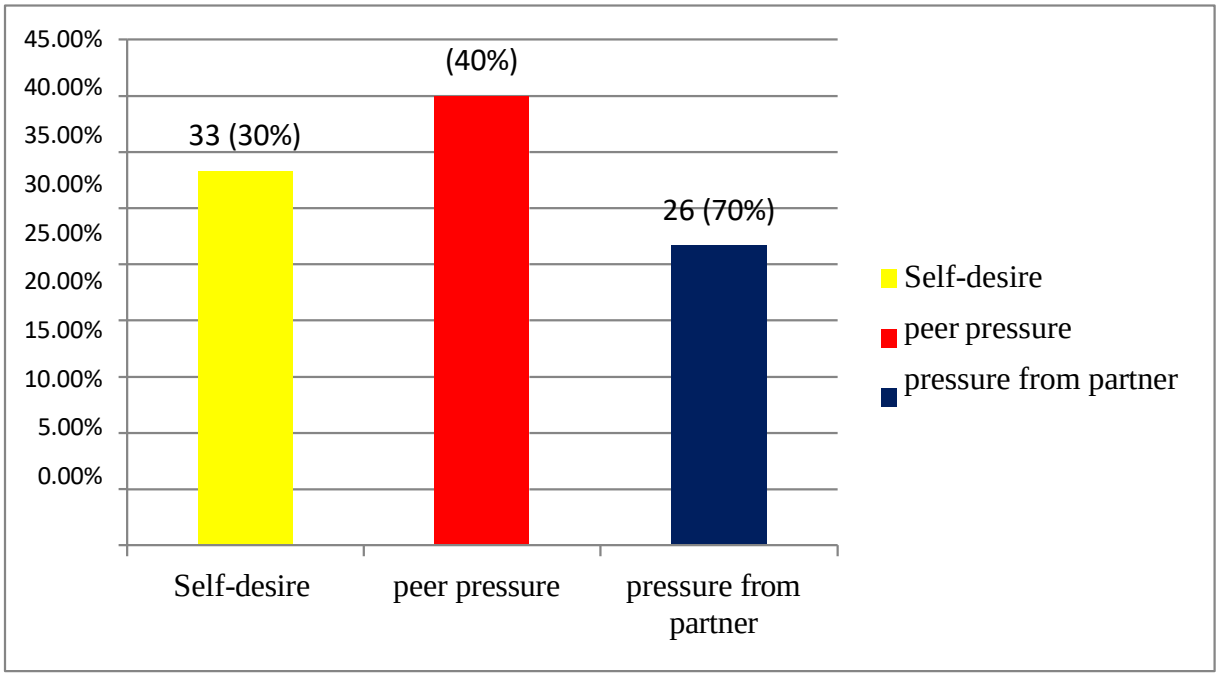

Figure 1 shows that the majority, 12(40%) of the respondents said that peer pressure led them to have sexual intercourse, while the least, 8(26.7%) of the respondents reported pressure from their partners.

Table 2: Shows respondents' information on whether they have ever heard about any method of controlling teenage pregnancy, N=30.

Variables	Categories	Frequencies (f)	Percentage (%)
Have you ever heard about any method of controlling teenage pregnancy?			
	Yes	12	40
	No	18	60
	Total	**30**	**100**

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Findings from table 2 indicated that the majority, 18(60%) of the respondents agreed that they have ever heard about methods of controlling teenage pregnancy, while a few, 12(40%) of the respondents have never.

Figure 2: Shows respondents' information on whether they have ever been taught/heard about the dangers of teenage pregnancy, N= (30).

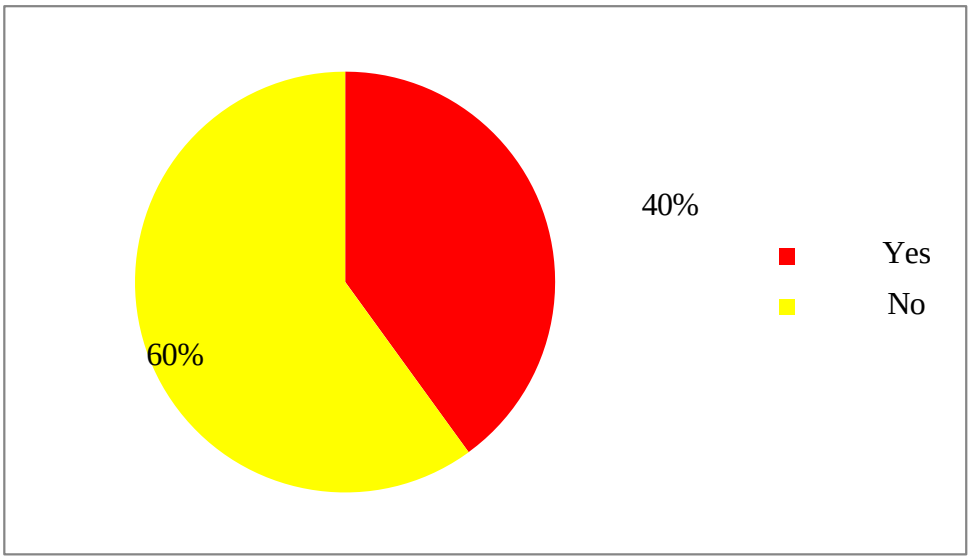
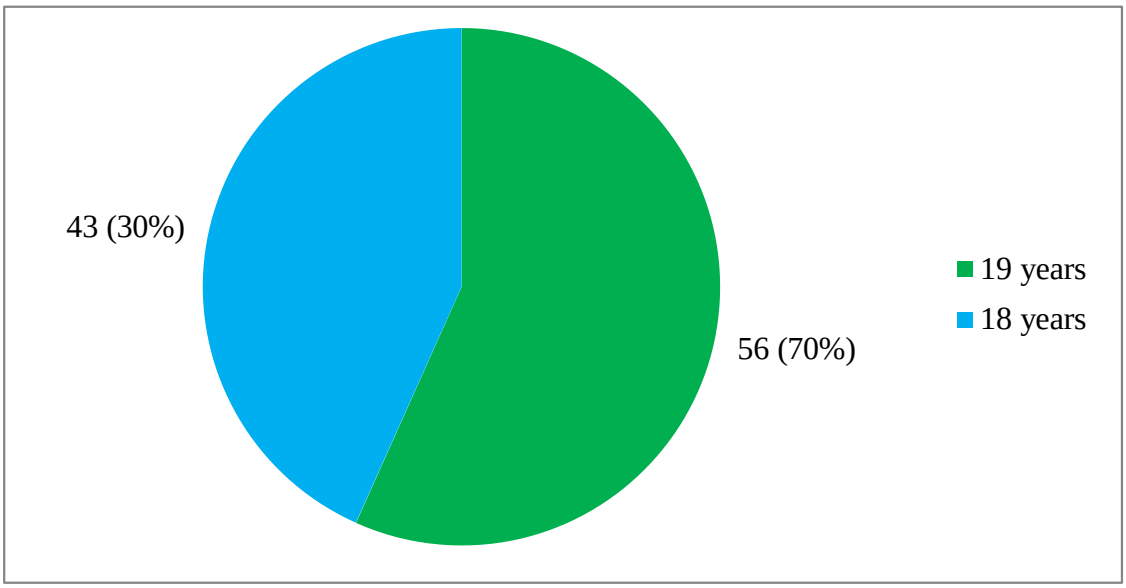


Figure 2 revealed that 18(60%) of the respondents said that they had never been taught/ heard about the dangers of teenage pregnancy, and 12(40%) had ever been taught/ heard about the dangers of teenage pregnancy.

Figure 3: Shows respondents' information on the most appropriate age to fall pregnant, n= (30)



Results from Figure 3 above, indicated that 17(56.7%) of the respondents reported the age of 19 years as the appropriate age for getting pregnant, and a minority, 13(43.3%) of the respondents reported 18 years.

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Socio-economic factors contributing to high teenage pregnancies.

Table 3: Shows respondents' information on the socio-economic factors contributing to high teenage pregnancies, n=30

Variables	Categories	Frequencies (f)	Percentage (%)
Do you think love for material gains could lead to teenage pregnancy in schools?			
	Yes	20	66.7
	No	10	33.3
What is your parent /guardian's occupation?			
	Unemployed	10	33.3
	Employed	12	40
	Self employed	8	26.7
Are you able to access the health facility in case you need any contraception? Method?			
	Yes	4	13.3
	No	26	66.7
Do you think teenagers get pregnant due to a lack of sexual education?			
	Agree		
	Disagree		
	Strongly disagree		
	Strongly agree		
Teenage pregnancy is very high among teenagers from a poor economic background.			
	Agree		
	Disagree		
	Strongly disagree		
	Strongly agree		
Media like pornographic movies can pressure teenagers into having sex earlier than expected, resulting in pregnancy.			
	Agree		
	Disagree		
	Strongly disagree		
	Strongly agree		

Table 3 indicates that 20(66.7%) of the respondents agreed that love for material gains could lead to teenage pregnancy in schools, and the minority, 10(33.3%) of the respondents did not agree.

The majority, 12(40%) of the respondents said that their parents are employed, and a few, 8 (26.7%) of the respondents were unemployed. More than half 26, 86.7%) of the respondents said that they can access the health facility in case they need any contraception method, while the minority 4, 13.3%) of the respondents were not able to access the health facility. Most 20(66.7%) of the respondents agreed that teenagers get pregnant due to a lack of sexual education, while a few 4(13.3%) of the respondents did not agree.

The majority, 18(60%) of the respondents strongly agreed that teenage pregnancy is very high among teenagers from a poor economic background, while the least 2(6.7%) of the respondents agreed.

A large number, 24(80%) of the respondents strongly disagreed that Media like pornographic movies can pressure teenagers into having sex earlier than expected, resulting in pregnancy, while the minority, 6(20%) of the respondents strongly agreed on that matter.

Cultural factors contributing to high teenage pregnancies.

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Figure 4: Shows respondents' information on whether parents are to be blamed for teenage pregnancies (N=30).

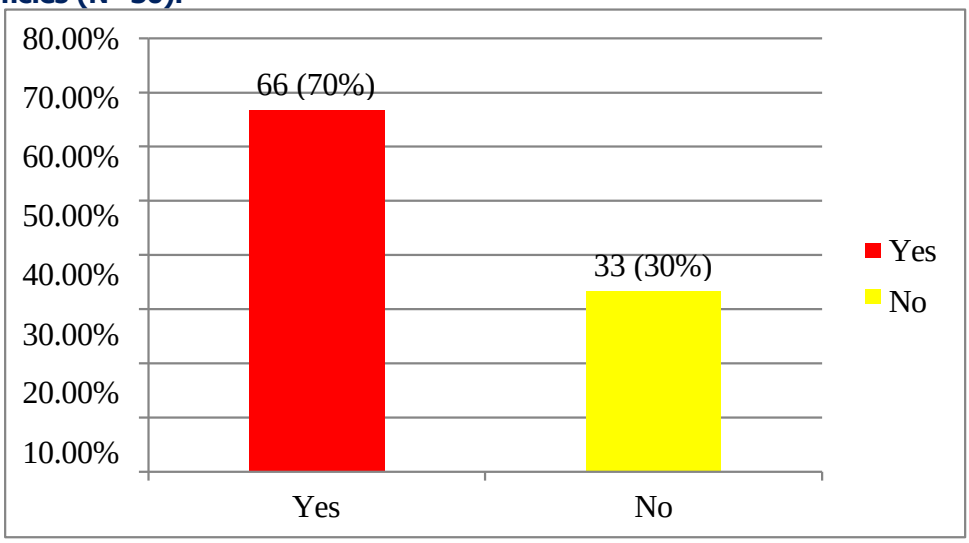

Figure 4 showed that 20(66.7%) of the respondents agreed that parents should be blamed for teenage pregnancies, while the rest, 10(33.3%) of the respondents, said that parents should not be blamed for teenage pregnancies.

Figure 5: Shows respondents' information on whether teenage pregnancy is one of the causes of increasing maternal mortality (N=30)

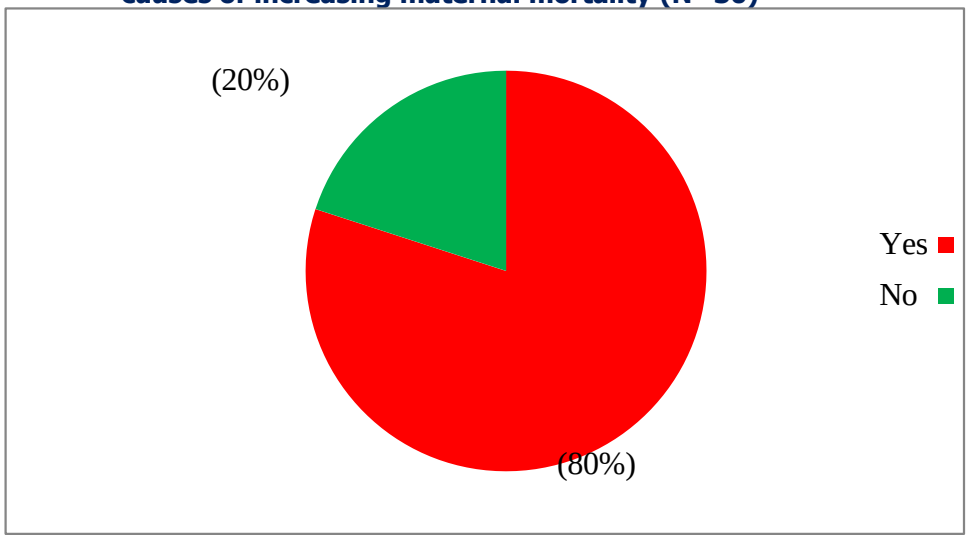

Figure 5 indicated that the majority24 (80%) of the respondents said that teenage pregnancy is one of the causes of increasing maternal mortality, while the least 6(20%) of the respondents did not agree.

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Figure 6: Shows respondents' information on whether they got pregnant during their first time of sexual intercourse (N=30).

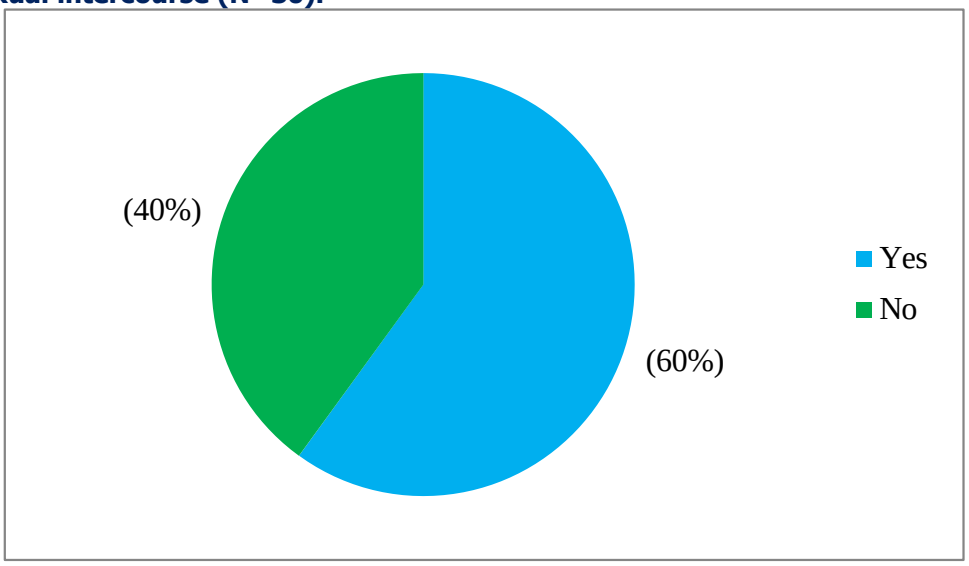

Figure 6 above, most 18(60%) of respondents said that they got pregnant during their first time of sexual intercourse, while a few, 12(40%), did not get pregnant during their first time of sexual intercourse.

Table 4: Shows respondents' information on whether peer groups influence teenage pregnancy (N=30).

Variables	Categories	Frequencies (f)	Percentage (%)
Do peer groups influence teenage pregnancy?			
	Yes	21	70
	No	9	30
	Total	**30**	**100**

Table 2 revealed that more than half 21(70%) of the respondents agreed that peer groups influence teenage pregnancy, and the rest (9, 30%) of the respondents did not agree with the matter.

Figure 7: Shows respondents' information on whether they have ever been forced or harassed into sexual activities by a friend or a teacher, N=30.

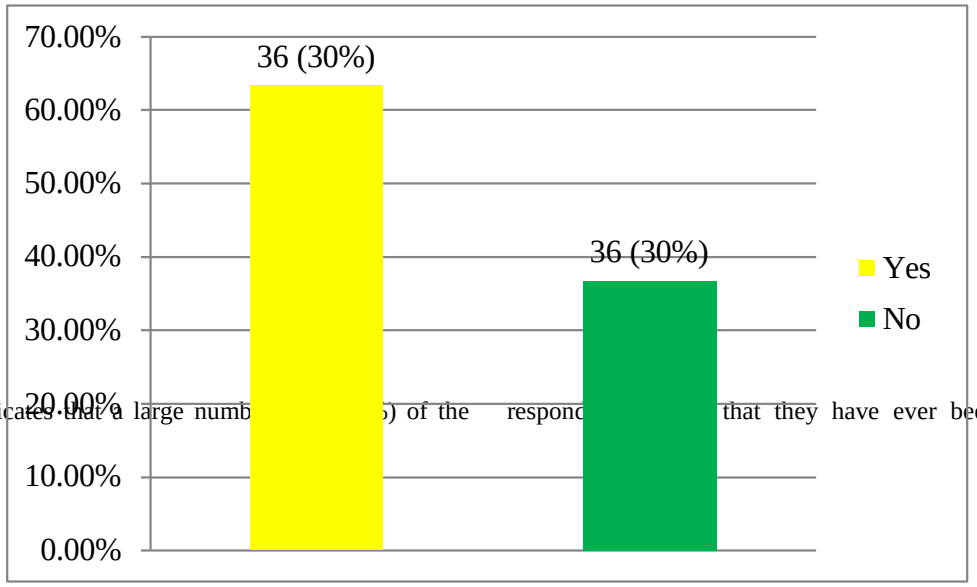

Figure 7 indicates that a large numb) of the respond that they have ever been forced or

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harassed into sexual activities by a friend or a teacher, while the minority, 11(36.7%) have never been forced or harassed into sexual activities by a friend or a teacher.

Figure 8: Shows respondents' information on who normally provides them with the most information about sexuality and reproduction, N=30

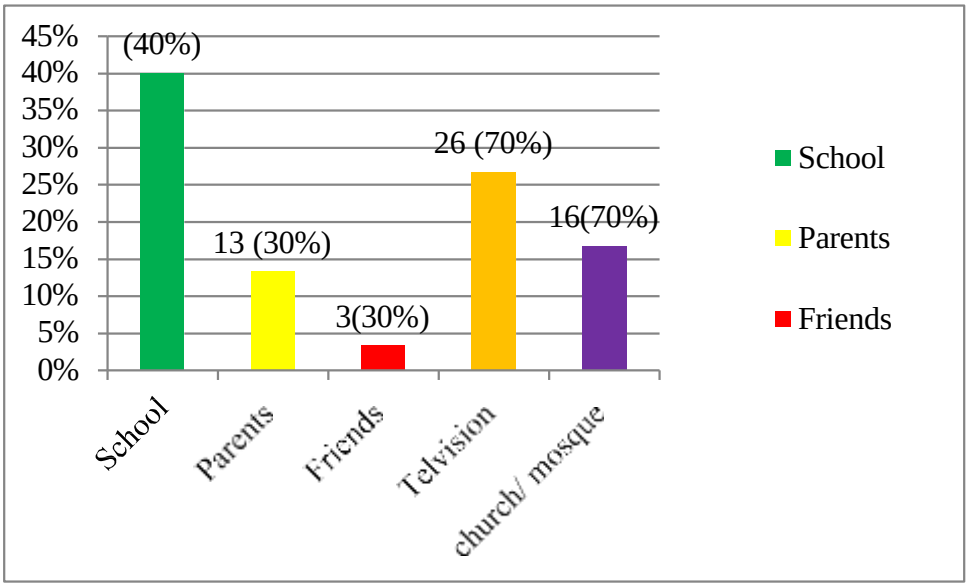

Figure 8 shows that 12(40%) of the respondents said that they got the information about sexuality and reproduction from school, while the least 1(3.3%) of the respondents said that they got the information from friends.

Figure 9: Shows respondents' information on whether teenage pregnancy may result from family dysfunction, as teenagers tend to seek love and affection elsewhere, N=30.

According to Figure 9 above, a large number of 18(60%) of the respondents strongly agreed that teenage pregnancy may result from family dysfunction, as teenagers tend to seek love and affection elsewhere, while a few 12(40%) did not agree.

Discussion of results.

Individual factors contributing to high teenage pregnancies.

The majority (40%) of the respondents said that peer pressure led them to have sexual intercourse, while the least (26.7%) reported pressure from their partners. Peer groups may influence these teenagers to engage in bad acts such as watching pornography, which may lead to early involvement in sexual activities, which can later lead to unwanted teenage pregnancies. This is in agreement with findings of the study done by Albert (2017), which indicated that there are social pressures that can push the teens towards becoming pregnant. Some girls feel that they will only be accepted as girls once they have proved their fertility.

The majority (60%) of the respondents agreed that they had ever heard about methods of controlling teenage pregnancy, whereas 40% of the respondents had never heard of them. Lack of information among young people about sex education is still a problem in the country because parents do not have enough time to sit with their children and talk about sex, parents have a misconception that topics on sex and relationships are taboo and should not be discussed with children, and this may result in many having unwanted pregnancies at an early age. The findings of this study are in line with the study done by Bezuidenhout (2018), which stated that African cultures encouraged a huge gap in communication about sexual issues between parents and their children and teenagers, especially girls, who experience body changes and find it difficult to discuss these changes with their parents.

Most (60%) of the respondents said that they have never been taught/ heard about the dangers of teenage pregnancy. Lack of awareness about the dangers of early teenage pregnancies may contribute to teenage pregnancies among many teenagers. This could be attributed to the fact that the majority had low levels of education, lacked parental guidance, and were not able to access the health care facility for health education about the dangers of teenage pregnancy. This is consistent with the study findings carried out by the Guttmacher Institute (2017) in the US, which found that one of the factors contributing to a high rate of teenage pregnancies is a lack of openness about sex in society.

Socio-economic factors contributing to high teenage pregnancies.

Most (66.7%) of the respondents agreed that love for material gains could lead to teenage pregnancy in schools, and (33.3%) of the respondents did not agree. This could be related to the fact that since many of these teenagers were coming from low socio-economic classes, where their parents were not able to pay their school fees, and end up being school dropouts, parents usually force them into early marriages, as many look at their daughters as a source of income for the family, hence teenage pregnancies. This is in agreement with findings of the study done in Sub-Saharan Africa by Daniel (2015), which indicated that the majority of teenage pregnancies are related to poverty because some teenage girls are involved sexually with older men in relationships where gifts are exchanged for sexual favors.

The majority (40%) of the respondents said that their parents are employed, and contrary to that, (26.7%) of the respondents were unemployed. Poverty in the family leads to early marriages due to the pressure from the parents, lack of access to the right information about contraception, and limited advice from parents to their children about sexuality, and this limits the teenager's knowledge of teenage pregnancy since they did not even attend sex education classes, as many dropped out of school early. This was in agreement with findings of the study done by Daniel (2015), which showed that teenagers who are born and have grown up in the circle of poverty may end up in prostitution as a way of compensating for the lack of salaries of their parents.

More than half (86.7%) of the respondents said that they can access the health facility in case they need any contraception method, whereas 13.3% of the respondents were not able to access the health facility. In ability to access the health facility may be accompanied by a lot of factors including lack of transport, long distances to the facility from their homes, harassment from the health care workers and lack of knowledge on the availability of contraception methods to use to prevent pregnancies and this has resulted into many teenage pregnancies since most teenage can access these services and counseling about their sexual life. This is in line with findings of the study done by Kintu & Zhu (2016), which indicated that many teenagers do not seek health care because they cannot afford transport costs to the health centers.

A large number (80%) of the respondents strongly disagreed that Media like pornographic movies can pressure teenagers into having sex earlier than expected, resulting in pregnancy, contrary 20% strongly agreed on that matter. The media portrays the glamorous side of sex in such a way that teenagers perceive sex as something in fashion. Many teenagers, especially girls, rely on magazines as an important source of information about sex, birth control, and health issues. This is in line with findings of the study done by Strasburger et al. (2012), which showed that media may function as a super-peer in terms of pressuring teenagers into having sex earlier than expected. Televisions, films, videos, magazines, advertisements, and novels, today, are full of sex and love.

Cultural factors contributing to high teenage pregnancies.

Most (66.7%) of the respondents agreed that parents should be blamed for teenage pregnancies, and (33.3%) said that parents should not be blamed for teenage pregnancies. This could be so because parents always have the mandate to look for their children from childhood to adulthood, teach their children about the dangers of early pregnancy, and ensure the education of their children. Neglect of these duties by the parents can lead to early involvement in sexual intercourse and early marriages by these teenagers. This was in agreement with findings of the study done by Bezuidenhout and Joubert (2018) in Amsterdam, which revealed that parents spend more time at work, and their concern is about shelter and food. Therefore, they neglect their children's emotional needs and development. This often leads to children spending more time with their peers and then copying them and older gang members or negative role models in the community.

Most (60%) of respondents said that they got pregnant during their first time of sexual intercourse, and contrary to that, 40% did not get pregnant during their first time of sexual intercourse. This could be related to the poor knowledge about contraception by these teenagers due to low education levels, and may also be related to the desires of these teenagers to explore the feelings associated with unprotected sexual intercourse. This was in line with findings of the study done by Gouws *et al*., (2018) in Africa, which revealed that many teenagers believe that the use of contraceptives make them sterile, Some teenagers believe that they can't get pregnant in the first time of sexual intercourse, if they are having their period, or if the male withdraws in time, and if they are having sex in a standing position. More than half (70%) of the respondents agreed that peer groups influence teenage pregnancy, and the rest (30%) of the respondents did not agree with the matter. Peer groups may influence these teenagers to engage in bad acts such as watching pornography, which may lead to early involvement in sexual activities, which can later lead to unwanted teenage pregnancies. This is in agreement with findings of the study done by Albert (2017), which indicated that there are social pressures that can push the teens towards becoming pregnant. Some girls feel that they will only be accepted as girls once they have proved their fertility.

A large number (63.3%) of the respondents agreed that they had ever been forced or harassed into sexual activities by a friend or a teacher. This implies that some adult males are among the facilitating factors that have been contributing to the increase in teenage pregnancy, as they use their opportunities to entice girls to participate in sexual practices.

This could have been caused by the pressure teenagers get from financial inducements received from adults. This is in line with findings of the study done by Jewkes *et al.* (2018), which showed that teenage Pregnancy issues in our world today have more effect on the lives of our teenage girls because they cause unwanted sex and teenage pregnancy. The 2016 Democratic and Health Survey in South Africa found that in schools, teachers were the most common perpetrators of teenage pregnancies among young girls.

Conclusion.

According to the study findings, individual factors contributing to teenage pregnancies were: peer pressure, lack of knowledge about contraception.

The socio-economic factors contributing to teenage pregnancies were: poverty, inaccessible health facilities, and misuse of media.

The cultural factors contributing to teenage pregnancies were: lack of parental guidance, sexual abuse and harassment, myths and misconceptions.

Limitations of the study.

There were constraints of balancing the time for research and other studies.

Encountered a constraint of a language barrier.

Recommendations.

The ministries should establish an approach that is more holistic to equip the teenagers with appropriate knowledge on sexuality, access to sexual and reproductive health services, rather than traditional coaching approaches that focus upon improving sexual ability, attitudes, and norms.

Media should produce features and editorials on the importance of ensuring all young Tanzanians have access to advice on reproductive health and the means to prevent unwanted pregnancy through life skills education and youth-friendly health services.

Nongovernmental and Civil Society Organizations should support community-based programmes that empower teenage girls to protect themselves and enable them to continue their education if they become pregnant while still at school.

Local Government Authority should introduce youth-friendly health services throughout the district and also ensure that all health facilities provide supportive and quality reproductive health services to teenagers so that they feel comfortable and confident about expressing their concerns in relation to reproductive health.

Acknowledgement.

I first give thanks to the almighty God, who by His love, care, and grace encouraged me to complete this report. I also extend my sincere gratitude to everyone who played a part in the accomplishment of this project. Specifically, I give thanks to my supervisor, Mr. Kakande Nelson, for his great support, courage, and, importantly, the time sacrificed and the professional guidance she accorded to me for the success of this report. I am very grateful to my lecturers, classmates, and friends like Ssetenda Moses and Kintu Micheal Kavuma for their moral and social support. Finally, I would like to appreciate my respondents for their positive response to my call to be part of the study.

List of abbreviations.

ANC:	Antenatal Clinic
WHO:	World Health Organization
UNFPA:	United Nations Fund for Population Activities
HOD:	Head of Department
KM:	Kilo Meter
UNICEF:	United Nations Children's Fund.

Source of funding.

There is no source of funding.

Conflict of interest.

The authors declare no conflict of interest.

Availability of data.

Data used in this study are available upon request from the corresponding author.

The author's contribution.

MN designed the study, conducted data collection, cleaned and analyzed data, drafted the manuscript, and NK supervised all stages of the study from conceptualization of the topic to manuscript writing.

Author's biography.

Majorine Nannono is a student of a diploma in nursing at Lubaga Hospital Training School.

Nelson Kakande is a research supervisor at Lubaga Hospital Training School.

References.

1. Albert M (2017). Adolescent Pregnancy and Policy in Uganda: Backgrounder, vol. 14.
2. Bezuidenhout and Joubert (2018). Protecting the Next Generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancy. GuttmacherMonograph.
3. Daniel T.T. (2015). Factors Contributing to Teenage Pregnancy in South Africa: Institute for Gender and Youth Studies, University of Venda, South Africa. J Sociology Soc Anth, 6(2): 273-277 (2015). https://doi.org/10.1080/09766634.2015.11885667
4. Gouws E, Burger S, Kruger N (2018). The

Adolescent Johannesburg: Heineman Publishers.
5. Jewkes R, Morrell R., Christofides N. (2018). Empowering teenagers to prevent pregnancy: lessons from South Africa." Culture, Health & Sexuality: 11 (7). https://doi.org/10.1080/13691050902846452
6. Ferede, T. A., Muluneh, A. G., Wagnew, A., & Walle, A. D. (2023). Prevalence and associated factors of early sexual initiation among female youth in sub-Saharan Africa: A multilevel analysis of recent demographic and health surveys. *BMC Women's Health*, *23*(1), 147. https://doi.org/10.1186/s12905-023-02298-z
7. Kakal, T., Nalwadda, C., van Reeuwijk, M., van Veen, M., Kusters, L., Chatterjee, O., Owekmeno, C., & Kok, M. (2022). Young people's choice and voice concerning sex and relationships: Effects of the multicomponent Get Up Speak Out! Programme in Iganga, Uganda. *BMC Public Health*, *22*(1), 1603. https://doi.org/10.1186/s12889-022-13919-x
8. Kintu, M. J., & Zhu, C. (2016). Student Characteristics and Learning Outcomes in a Blended Learning Environment Intervention in a Ugandan University. *Electronic Journal of E-Learning*. https://www.semanticscholar.org/paper/Student-Characteristics-and-Learning-Outcomes-in-a-Kintu-Zhu/2642dc90b2eeb3072aed4db3aedefc982bd837b5
9. Kyegombe, N., Meiksin, R., Wamoyi, J., Heise, L., Stoebenau, K., & Buller, A. M. (2020). Sexual health of adolescent girls and young women in Central Uganda: Exploring perceived coercive aspects of transactional sex. *Sexual and Reproductive Health Matters*, *28*(1), 1700770. https://doi.org/10.1080/26410397.2019.1700770
10. Manzi, F., Ogwang, J., Akankwatsa, A., Wokali, O. C., Obba, F., Bumba, A., Nekaka, R., & Gavamukulya, Y. (n.d.). *International Online Medical Council (IOMC)*. Retrieved January 14, 2025, from https://www.iomcworld.org/
11. Panda, A., Parida, J., Jena, S., Pradhan, A., Pati, S., Kaur, H., & Acharya, S. K. (2023). Perception, practices, and understanding related to teenage pregnancy among the adolescent girls in India: A scoping review. *Reproductive Health*, *20*(1), 93. https://doi.org/10.1186/s12978-023-01634-8
12. Scott, S., Nguyen, P. H., Neupane, S., Pramanik, P., Nanda, P., Bhutta, Z. A., Afsana, K., & Menon, P. (2021). Early marriage and early childbearing in South Asia: Trends, inequalities, and drivers from 2005 to 2018. *Annals of the New York Academy of Sciences*, *1491*(1), 60–73. https://doi.org/10.1111/nyas.14531
13. Strasburger, V. C., Jordan, A. B., & Donnerstein, E. (2012). Children, adolescents, and the media: Health effects. *Pediatric Clinics of North America*, *59*(3), 533–587, vii. https://doi.org/10.1016/j.pcl.2012.03.025

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