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Influential Factors in Teenage Pregnancy, Kitagata Sub County, Sheema District, Southwestern Uganda

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ABSTRACT

The study aimed to evaluate the factors influencing teenage pregnancy in Kitagata sub-county, Sheema district, Uganda. Seventy teenage pregnant girls were selected using the Kish Leslie formula (1995). Data was collected through a questionnaire and analyzed using SPSS. The results showed that 25.0% of the 54 teenage pregnant girls had their first pregnancies, 37.1% used birth control methods, and 41.7% used a condom. 65.5% had trust in partners, while 51.4% were motivated by sexual intercourse. The majority of the girls needed love, fear rejection, and wanted to understand the experience of sexual intercourse. The majority started sexual intercourse as young as 12 years and below, and between 13-15 years of age. The majority of the girls lived with their parents or guardians, who often blammed them for their sexual behavior. The majority of the girls felt lonely and had no pregnancy prevention information. The study found that anxiety, curiosity, early age sexual intercourse initiation, and living with guardians were the main motivators for teenage pregnancy.

Keywords: associated factors, teenage; pregnancy

INTRODUCTION

Teenage pregnancy is defined as a teenage girl, usually within the ages of 13-19, becoming pregnant. The term in everyday speech usually refers to girls who have not reached legal adulthood, which varies across the world, who become pregnant [1, 2].

Globally, an estimated 16 million young women aged 15 to 19, and about a million girls under 15 years of age give birth every year [3]. A point of concern is that in Afghanistan, Timor-Leste and 15 countries in sub-Saharan Africa, half the population is under 18.

More to that in Chad, Niger and Uganda, half are under 16 [4]. In some regions of the world, however, early childbearing remains common and in 2008, adolescents aged 15–19 in developing countries had an estimate of 14.3 million births and 3.2 million abortions [5]. Of which the rates of adolescent pregnancy were seen to have increased in developing countries [6]. Furthermore, of the 11% births globally which occur to adolescents aged 15 to 19 years annually, 95% of these births occur in developing countries [7]. This was supported by another study where approximately 90% of births to girls aged 15-19 in developing countries occur within early marriage where there is often an imbalance of power, no access to contraception and pressure on girls to prove their fertility [8].

In Africa, the overall pooled prevalence of adolescent pregnancy was 18.8% and 19.3% in the Sub-Saharan African region. The prevalence was highest in East Africa (21.5%) and lowest in Northern Africa (9.2%) [6]. Furthermore, the incidence of adolescent pregnancy was highest in Sub Saharan Africa that is 143 per 1,000 girls aged between 15-19 years [9]. Another study showed that each year, about 14 million pregnancies occur across sub-Saharan Africa, with nearly half of them occurring among women aged 15–19 years [10]. It was also revealed that teenage pregnancy decreased in East Africa, plateaued in West Africa and increased slightly in Southern Africa between 1992 and 2011 [11].

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Since in Africa pre-marital sex is not accepted especially for young women under 18 years. This often implies secret, unsafe abortions under unhygienic conditions performed by people who lack the necessary skills and in places that do not meet minimal medical standards [12]. Additionally, teenager mothers are at higher risk of obstetric complications such as: incontinence from obstetric fistulae, eclampsia, post-partum hemorrhage, sepsis and a five-fold increased risk of maternal mortality [13]. Additionally, disadvantageous prospects exist for the teenage mother, including lower educational attainment and school dropout resulting in lower income-earning potential and perpetuation of poverty [14]. Secondly, the children that teenagers bear experience higher levels of birth complications, poor health outcomes and deprivation [15]. Therefore, curbing teenage pregnancy has become an urgent health and social matter, particularly in sub-Saharan Africa [11].

Some African countries have attempted an integrated approach to sexual health promotion among young people were sexually transmitted infection, HIV and pregnancy prevention information and services are provided together [16]. For example, in Madagascar provision and mass awareness of youth-friendly clinics was implemented since 2001. Additionally, Cameroon undertook peer education to empower youth on issues such as dating, peer-pressure, sexuality as well as prevention of pregnancy and disease [16].

In Uganda, 25 percent of young women age 15–19 had begun childbearing in 2015 [17]. However most sexually active young people in Uganda, do not use contraceptives and 31% of those aged 12–18 years were not using any contraceptive method at their last sexual encounter [18]. Although in Uganda, knowledge of the existence of contraceptives seems superficial as evidence shows that 21% of young women and 46% of young men who knew the pill did not know that it has to be taken daily for it to be effective [17]. Beyond this knowledge gap, studies show that contraceptive usage in Uganda is also influenced by young women feeling too inhibited and ashamed to seek contraception services or because contraceptives are not easily available [19].

The prevalence of teenage pregnancy in Kibuku District was reported to be 35.8% in 2016, higher than the average rate for rural areas in Uganda estimated at 27%. Bad peer groups, enticement with gifts and poverty were the most common causes of teenage pregnancy while school dropout at 48%, broken marriages and miscarriages at 9% were recorded as its major effects [20]. Additionally, women with more than secondary education initiate sex nearly four years later than women with no education (19.8 years versus 16.0 years) [17].

METHODOLOGY

Study design

This study employed a cross sectional descriptive study [21] design using quantitative method for data collection.

Area of study

This study was carried out in Kitagata sub county, Sheema district, south western Uganda. It has eight parishes and 81 villages. It lies on the Ishaka-Kagamba road. It is approximately 17 Km south west of Ishaka -Bushenyi district.

Population of the study

The target population for the research was pregnant teenagers in Kitagata sub county, Sheema District.
Study population was obtained according to selection criteria, that is inclusion and exclusion criteria.

Inclusion and Exclusion Criteria

Inclusion: Pregnant teenagers in Kitagata Sub County at the time of the study who consented to take part in the study.

Exclusion Pregnant mothers in Kitagata Sub County at the time of the study/before/after the study that did not consent to take part in the study were excluded. Pregnant teenagers who were not in Kitagata Sub County were also excluded.

Sample size

The sample size was determined using the Kirsch and Leslie (1965) formula.

$$S = \frac{Z^2{}_{\propto/2} \times P(1-P)}{\delta^2}$$

Where;
S = the sample size
Z = 1.96 at 95% confidence interval.
δ= 5% Margin of error

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P= is the proportion of the target population estimated to have the same characteristics therefore P was 27%=0.27 [17]
Therefore, substituting for values in this formulae
$N= 1.96^2 * 0.27 (1-0.27) / 0.05^2$
$N= 3.8416*0.1971/0.0025$
$N=0.75717936/0.0025$
N=302.871744
However, using the "Finite Population Correction for Proportions" formula
$n = \frac{n1}{1 + (\frac{n1-1}{N})}$ where N is the population size (for this case number of women of reproductive age at the hospital, =90) and n1 is the sample obtained above;
Sample size will be; $\frac{302.871744}{4.354130488888889} = 69.55963877814063$
Therefore, 70 pregnant teenagers were sampled.
The sample size was 70 pregnant teenagers

Sampling procedure

All pregnant teenagers who visited the Kitaga Health Centre IV for ANC during the time of study and consented were recruited.

Data collection procedure

An introductory letter was obtained from the office of the Dean of Faculty of Clinical Medicine and Dentistry of KIU. This was used to gain access and create rapport with Kitagata Health Centre IV Medical Superintendent. The cover letter had explanation of the purpose of the study. The researcher sought and obtained permission from the hospital administration before accessing respondents and obtained.
Informed consent from each respondent was also requested for and obtained.

Data processing, analysis and interpretation

The data was cleaned right from the field by crosschecking all the questionnaires to ensure that all the required information were captured. All the data were entered into Excel and then transferred to SPSS 20.0 version (Statistical Package for Social Scientists) for analysis. Analyzed data were then processed using Microsoft Word, interpreted and presented using descriptive tables, bar graphs, pie charts among others for better understanding. The researcher then elaborated the findings of the research in a research report.

Ethical issues

An introductory letter was obtained from the administration of Kampala International University–Western Campus to carry out the study and it was then taken to the Medical Superintendant of Kitagata Hospital to obtain permission to conduct research in the area. The participants were then informed about the purpose of the study and what use would be made of the data. Informed consent was obtained verbally and in written and no reward was offered to the participants [22].

RESULTS

According to the study findings; the majority 38(54.3%) aged between 13 and 16 years. Twenty-three (32.9%) had no occupation whereas those with occupation 15 (21.4%) were mostly farmers. Marital status; majority, 32 (45.7%) were married, followed by 31 (44.3%) singles whereas 7 (10.0%) were divorced/separated.
See table 1.

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Table 1: Sociodemographic characteristics of the study participants

Variable	Frequency (N)	Percentage (%)
Age		
13-16	38	54.3
17-19	32	45.7
Level of education		
None	4	5.7
Primary	26	37.1
Secondary	38	54.3
Tertiary	2	2.9
Occupation		
None	23	32.9
Farmer	15	21.4
House wife	9	12.9
Sex worker	9	12.9
Others	14	20.0
Marital status		
Single	31	44.3
Married	32	45.7
Divorced	7	10.0

According to the study findings, only 3(25.0%) of the total 54(77.1%) first pregnancies, were planned. This was statistically significant with p=<0.001 and OR=0.05(0.1-0.21). All 4(100.0%) with planned pregnancies, never resisted to intercourse among the non-planned pregnancies, a considerable number 12(36.4%) resisted intercourse, p=0.01, p=1.19(1.00-1.41).

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Table 2: The individual factors influencing teenage pregnancy in Kitagata Sub County, Sheema district south western Uganda.

Variable	Teenage Pregnancy		TOTAL N (%)	p	OR [95% C.I]
	Planned	Not planned			
First pregnancy					
Yes	**3(25.0%)**	**51(87.9%)**	**54(77.1%)**	**<0.001**	**0.05(0.01-0.21)**
No	9(75.0%)	7(12.1%)	16(22.9%)	Ref	1
Consented to Intercourse					
Yes	5(41.7%)	33(56.9%)	38(54.3%)	0.34	0.54(0.15-1.91)
No	7(58.3%)	25(43.1%)	32(45.7%)	Ref	1
Resisted Intercourse					
Yes	**0(0.0%)**	**12(36.4%)**	**12(32.4%)**	**0.01***	**1.19(1.00-1.41)**
No	4(100.0%)	21(63.6%)	25(67.6%)	Ref	1
Drugs and/alcohol use					
Yes	8(66.7%)	37(63.8%)	45(64.3%)	0.85	1.14(0.31-4.23)
No	4(33.3%)	21(36.2%)	25(35.7%)	Ref	1
Knows birth control methods					
Yes	10(83.3%)	42 (72.4%)	52 (74.3%)	0.43	1.91(0.38-9.67)
No	2 (16.7%)	16(27.6%)	18(25.7%)	Ref	1
Used birth control methods					
Yes	**8(66.7%)**	**18(31.0%)**	**26(37.1%)**	**0.02***	**4.44(1.18-16.69)**
No	4(33.3%)	40(69.0%)	44(62.9%)	Ref	1
Birth control method Used					
Condom	**5(41.7%)**	**6(10.3%)**	**11(15.7%)**	**0.02***	**-**
Other	3(25.0%)	12(20.7%)	15(21.4%)	-	-
None	4(33.3%)	40(69.0%)	44(62.9%)	-	-
Birth control access difficult					
Yes	4(33.3%)	32(55.2%)	36(51.4%)	0.17	0.41(0.11-1.50)
No	8(66.7%)	26(44.8%)	34(48.6%)	Ref	1
Currently in school					
Yes	3(25.0%)	12(20.7%)	15(21.4%)	0.74	1.28(0.29-5.46)
No	9(75.0%)	46(79.3%)	55(78.6%)	Ref	1
Attended sex oriented sensitization					
Yes	6(50.0%)	40(69.0%)	46(65.7%)	0.21	0.45(0.13-1.59)
No	6(50.0%)	18(31.0%)	24(34.3%)	Ref	1
Duration with boyfriend					
Months	1(8.3%)	15(28.8%)	16(25.0%)	0.14	0.22(0.03-1.89)
≥1 years	11(91.7%)	37(71.2%)	48(75.0%)	Ref	1
Developed trust					
Yes	**12(100.0%)**	**38(65.5%)**	**50(71.4%)**	**0.02***	**0.76(0.65-0.89)**
No	0(0.0%)	20(34.5%)	20(28.6%)	Ref	1
Sexual intercourse strengthened your relationship					
Yes	**12(100.0%)**	**24(41.4%)**	**36(51.4%)**	**<0.001***	**0.67(0.53-0.84)**
No	0(0.0%)	34(58.6%)	34(48.6%)	Ref	1

***Statistically Significant, P-Value=<0.05 OR=Odds Ratios Ref=Reference category**

Similarly, a considerable 26(37.1%) used birth control methods and were majority 8(66.7%) of those with planned pregnancies p=0.02, OR=4.44(1.18-16.69); most 5(41.7%) of whom with a planned pregnancy used a condom. however, majority 44(62.9%) never used any form of contraceptive methods. Having developed Trust in their partners/relationships, majority 38(65.5%) of those with trust got unplanned teenage pregnancy, p-value=0.02,

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OR= 0.76(0.65-0.89). more so, 36(51.4%) p=<0.001 and OR=0.67(0.53-0.84) were motivated by sexual intercourse. General majority of the teenage pregnancies were not planned and resulted from a sexual inter course from failure to resist to having a sexual intercourse due mostly 31.4%, 30.0% and 21.45 needing to be loved more, fear of being rejected, and wanting to find out how it feels like during sexual intercourse respectively. The majority, 35.7% of the unplanned teenage pregnancies were among those who started sexual intercourse as early as 12 years and below as well as among those 13-15 years (31.4%) whereas only 15.7% was among those who started and had their first sexual intercourse at 16-18 years of age.

According to the study findings, at household level; the studied factors were not statistically significant. However, majority 39(55.7%), 44(62.9%), 50(71.4%), and 46(65.7%) were living with their parents/guardians, whose sexual talks were mostly blaming type than guiding, with some pregnancy preventing information in the past and many reported their parents to be generally irresponsible respectively. Similarly, 54(77.1%) reported having felt lonely and only 39(58.2%) had all their parents alive. More so, a considerable number with especially unplanned teenage pregnancies 25(43.1%) were living with guardians, whose sexual talks were mostly 38(65.5%) with 18(31.0%) reporting no pregnancy prevention related information in the past. Many 36(62.1%) put it that their parents were irresponsible; rendering 44(75.9%) to a feeling of loneliness though 28(41.8%) never had all their parents alive.

Table 3: The house hold factors influencing teenage pregnancy in Kitagata sub county, Sheema District south western Uganda

Variable	Teenage Pregnancy		TOTAL N (%)	p	OR [95% C.I]
	Planned	Not planned			
Living with parents/guardian					
Yes	6(50.0%)	33(56.9%)	39(55.7%)	0.66	0.76(0.22-2.63)
No	6(50.0%)	**25(43.1%)**	31(44.3%)	Ref	1
Sexual talk nature					
Blaming	6(50.0%)	**38(65.5%)**	44(62.9%)	0.31	0.53(0.15-1.85)
Guiding	6(50.0%)	20(34.5%)	26(37.1%)	Ref	1
Pregnancy prevention information in the past					
Yes	10(83.3%)	40(69.0%)	50(71.4%)	0.32	2.25(0.45-11.33)
No	2(16.7%)	**18(31.0%)**	20(28.6%)	Ref	1
Parents irresponsibility					
Yes	10(83.3%)	**36(62.1%)**	46(65.7%)	0.16	3.06(0.61-15.26)
No	2(16.7%)	22(37.9%)	24(34.3%)	Ref	1
Lonely feeling					
Yes	10(83.3%)	**44(75.9%)**	54(77.1%)	0.58	1.59(0.31-8.14)
No	2(16.7%)	14(24.1%)	16(22.9%	Ref	1
Parents hated me					
Yes	4(33.3%)	24(41.4%)	28(40.0%)	0.61	0.71(0.19-2.62)
No	8(66.7%)	34(58.6%)	42(60.0%)	Ref	1
All parents alive					
Yes	6(54.5%)	33(58.9%)	39(58.2%)	0.79	0.84(0.23-3.07)
No	5(45.5%)	23(41.1%)	28(41.8%)	Ref	1

***Statistically Significant, p=<0.05 OR=Odds Ratios Ref=Reference category**

district south western Uganda.

Table 4: The community factors influencing teenage pregnancy in Kitagata Sub County, Sheema District south western Uganda

Variable	Teenage Pregnancy		TOTAL N (%)	p	OR [95% C.I]
	Planned	Not planned			
Given tokens for sex/relationship					
Yes	**12(100.0%)**	**41(70.7%)**	**53(75.7%)**	**0.031***	**0.77(0.67-0.9)**
No	0(0.0%)	17(29.3%)	17(24.3%)	Ref	1
Boyfriend older					
Yes	8(66.7%)	50(86.2%)	58(82.9%)	0.10	0.32(0.08-1.32)
No	4(33.3%)	8(13.8%)	12(17.1%)	Ref	1
Forced sex					
Yes	**0(0.0%)**	**29(90.6%)**	**29(85.3%)**	**<0.001***	**1.67(1.0-3.41)**
No	2(100.0%)	3(9.4%)	5(14.7%)	Ref	1
Community sexual education					
Yes	6(50.0%)	28(48.3%)	34(48.6%)	0.91	1.07(0.31-3.72)
No	6(50.0%)	30(51.7%)	36(51.4%)	Ref	1

***Statistically Significant, p=<0.05 OR=Odds Ratios Ref=Reference category**

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According to the study findings, of the 53(75.7%) who were given tokens 41(70.7%) had un planned pregnancies with a p= 0.031, OR=0.77(0.67-0.9) whereas all 29(90.6%) forced into sexual intercourse acquired an unplanned pregnancy p=<0.001; OR=1.67(1.0-3.41).

DISCUSSION

According to the study findings, only 3(25.0%) of the total 54(77.1%) first pregnancies, were planned and was statistically significant with p=<0.001 and OR=0.05(0.1-0.21). This could be the reason for many teenage pregnancies which are first pregnancies in m=number. These findings coincide with a survey by [13] in which it was found that 29% of the teens were pressurized to have sex, 33% were sexually active and they felt things were moving fast sexually. The immature and irresponsible behavior arising due to psychological factors and the complex teenage psychology is another important cause of teenage pregnancies. Teenagers often go through a number of emotions because of their own transition from childhood and peer pressure. Also, the girls never resisted to intercourse among the non-planned pregnancies, a considerable number 12(36.4%) resisted intercourse, p=0.01, p=1.19(1.00-1.41). This complements a study which put it that a teen's ability to control her impulses thus contributing to 75% of pregnancies that occur between the ages of 14 and 21 [24].

Knowledge plays a vital role in decision making that influences health and development, there is limited knowledge amongst adolescents about sex and family planning, and lack of skills to put that knowledge into practice because effective sexuality education is lacking in many countries. In married or unmarried adolescent girls, some pregnancy is accidental and results from experimenting with sexuality or lacking knowledge about how to prevent conception. Similarly, a considerable 26(37.1%) used birth control methods and were majority 8(66.7%) of those with planned pregnancies p=0.02, OR=4.44(1.18-16.69); most 5(41.7%) of whom with a planned pregnancy used a condom. however, majority 44(62.9%) never used any form of contraceptive methods. This agrees with the fact that Lack of sufficient knowledge of the preventive measures, not using birth control devices or they failing at times are also reasons for teenage pregnancy. Most authors agree that one of the factors in teenage pregnancy is resistance to contraception. Resistance to contraception takes one of two forms: either no contraceptive is used or a contraceptive is used improperly [13].

Having developed Trust in their partners/relationships, majority 38(65.5%) of those with trust got unplanned teenage pregnancy, p=0.02, OR= 0.76(0.65-0.89). more so, 36(51.4%) p=<0.001 and OR=0.67(0.53-0.84) were motivated by sexual intercourse. Many times these teens let their friends influence their decision to have sex even when they do not fully understand the consequences associated with the act [24].

General majority of the teenage pregnancies were not planned and resulted from a sexual inter course from failure to resist to having a sexual intercourse Some teens have said to be pressured into having sex with their boyfriends at a young age and yet no one had taught these teens how to deal with this pressure or to say "no". Fear of asserting oneself and fear of rejection is very common among young people [23]. in this study it was mostly due to31.4%, 30.0% and 21.45 needing to be loved more, fear of being rejected, and wanting to find out how it feels like during sexual intercourse respectively. This is in line with a study which concluded that Most often, the young woman fears that she was rejected by her partner if she refuses to have unprotected sex or insists that he uses a condom [19]. Similarly, it is also argued that both sexes show interest in and explore the much hyped topics of sex, thanks to the irresponsible and careless approach of mass media. This makes them vulnerable to teenage sex and pregnancy without adequate sex education. Therefore, lack of sexual education causes teens to get abortions as they ultimately realize their inability to bear the responsibilities of being a parent at such a young age [25]. A qualitative study that was conducted in London to identify factors that shape young people's sexual behaviour, revealed that adolescent girls may perceive agreeing to have sex as a way of holding on to their boyfriends.

Majority35.7% of the unplanned teenage pregnancies were among those who started sexual intercourse as early as 12 years and below. This was found to agree with a report by [17], adolescent sexual behavior among the adolescents and peer pressure is a major factor that encourages teenage boys and girls to indulge in early dating and sexual activities as early as 12 years.

According to the study findings, majority were living with their parents/guardians, whose sexual talks were mostly blaming type than guiding. This complements a study by [23] in which they reported that lack of parental guidance is another cause as most parents prevent their children from talking about sex. In some cases, they provide false information regarding sex and discourage their children from indulging or participating in informative discussions about sex. Sometimes teenage mothers are not well educated about sex before getting pregnant and this leads to lack of communication between the parents and the children. Also, only a few reported having acquired some pregnancy preventing information in the past yet many reported their parents to be generally irresponsible respectively. This is relative to a report compiled in the United States by the policy analyst highlights that sexual conversations between parents and teenagers is helpful in delaying sexual initiation.

Similarly, majority reported having felt lonely. This contributes to the existing knowledge which stipulates that Domestic or sexual violence is also another cause of teenage pregnancy. Girls run away from school or their parents'

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home to live with other relatives due to violence and this is where they conceive from [14]. In addition, weak family relationships fail to provide the emotional support that teenagers require and this lack of attention and affection from family results into depression forcing them to seek love and support from other people, especially members of the opposite sex [5] and only 39(58.2%) had all their parents alive yet it is the duty of the parents to impart adequate sex education and education regarding reproductive health to their adolescent sons and daughters so that their children become aware of the various aspects related to teenage sex and pregnancy [26]. More so, a considerable number with especially unplanned teenage pregnancies 25(43.1%) were living with guardians, whose sexual talks were mostly 38(65.5%) blaming type with 18(31.0%) reporting no pregnancy prevention related information in the past. Many parents have busy lives that prevent them from providing the guidance and support that their young teenagers need to make good decisions on issues such as sex [23]. Furthermore, many 36(62.1%) put it that their parents were irresponsible; rendering 44(75.9%) to a feeling of loneliness though 28(41.8%) never had all their parents alive. Orphans usually lack the required supervision by parents and are also susceptible to sexual abuse. According to a report "Improving Sexual and Reproductive Health Rights for out of School Young People" by Dr. Stella Neema Nyanzi from Makerere Institute of Social Research, orphan hood leads to early sexual behavior as young girls start living on their own at an early age [25].

According to the study findings, the majority of those who were given tokens got unplanned pregnancies. This had a p= 0.031 and reduced the possibility of a planned pregnancy by 0.77(0.67-0.9) odds. This agrees with a study by [27] in which it was concluded that the social economic factor is clearly spelled out as teenage girls who belong to poor families are more likely to become pregnant. Researchers have found out that even in developed countries, teenage pregnancy occurs mostly among the deprived sections of families. Most young women live in poverty and are always under peer pressure which often forces them to turn to sex in exchange for gifts. All those forced into sexual intercourse (raped) acquired an unplanned pregnancy p=<0.001; this increased the odds for a teenage pregnancy by 1.67 (1.0-3.41) times more. This agrees with a study by [28] in which it was found that Sexual abuse of teenage girls is also one of the most disgraceful causes of teenage pregnancy. Teens have become pregnant as a result of sexual abuse (rape and defilement). The Guttmarcher Institute stated that between 43% and 62% of teens acknowledge that they were impregnated by an adult male and two-thirds reported that their babies' fathers were as old as 27. Approximately 5% of all teen births are as a result of rape.

Nonetheless, only a few reported having had community sexual education. This complements a study which stated that Sex education in schools is limited and the young girls are also not informed of contraceptive use. More to that most of these girls are from rural areas and sex education in schools is limited [5]. Similarly, the victims of unplanned pregnancies had attended Government schools as well as majority of the planned teenage pregnancies. As well, [25] suggested that the government really needs to do more. Schools and society also need to emphasize the risk factors associated with unprotected sex as well as the outcomes of unplanned teenage pregnancy not to mention the significance of moral and ethical values.

CONCLUSION

At individual level, Anxiety to maintain relationships and/or curiosity, and early age sexual intercourse initiation motivated teenage pregnancy. Similarly, at household level, living with guardians, whose sexual talks were mostly blaming type instead of guiding, limited or no pregnancy prevention related information in the past, irresponsible parents; rendering a feeling of loneliness and loss of biological parent(s). Community level, tokens, lack of school and/or community based sexual education as well as forced sexual intercourse (rape) increased the possibility of a teenage pregnancy. However, Use of birth control methods especially a condom as well as avoiding sexual relationships if possible could reduce the trend.

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