http://www.inosr.net/inosr-applied-sciences/
Apili
INOSR APPLIED SCIENCES 11(1):13-24, 2023

International Network Organization for Scientific Research ISSN: 2705-165X
https://doi.org/10.59298/INOSRAS/2023/2.6.4000

# Influential Elements Impacting Adolescent Pregnancy in Teen Mothers Seeking Antenatal Care at Fort Portal Regional Referral Hospital, Kabarole District

**Apili Everlyne**

**Faculty of Clinical Medicine and Dentistry Kampala International University Western Campus Uganda.**

## ABSTRACT

In sub-Saharan Africa, approximately 14 million pregnancies arise annually, with almost half occurring among women aged 15–19. Uganda saw 25% of young women in that age bracket beginning childbearing in 2015. The primary aim of the study was to identify factors influencing teenage pregnancy among adolescent mothers receiving antenatal care at Fort Portal Regional Referral Hospital in Kabarole district. Using a cross-sectional descriptive design, 288 teenage girls were randomly selected for participation. The majority (51.4%) fell within the 17-19 age range, 72.9% were unmarried, 54.5% had attained a Secondary education level, and most (60.4%) lived in rural areas. The teenage pregnancy rate stood at 25.7%. Individual factors significantly linked to teenage pregnancy included inadequate contraceptive use and alcohol misuse. Household-related factors associated with teenage pregnancy encompassed orphanhood, low-income status (poverty), absence of parental guidance, and teenage girls not residing with their parents. Community factors significantly tied to teenage pregnancy among those attending antenatal care at Fort Portal regional referral hospital included peer influence, exposure to pornographic content, limited access to reproductive health services, and cultural norms. These cultural practices involved early and arranged marriages, along with coerced sex with witch doctors disguised as healers.
The researcher suggested that Uganda's government establish additional centers, particularly in rural areas, to address limited access to reproductive health services. Additionally, regulating alcohol and drug use among teenagers by restricting access to these substances was recommended.
**Keywords:** Teenage Pregnancies, Antenatal care, teenage mothers, teenage girls, Parents.

## INTRODUCTION

Globally, and largely in low and middle-income countries, an estimated 16 million young womenaged 15 to 19, and about a million girls under 15 years of age give birth every year [1]. Each year, about 14 million pregnancies occur across sub-Saharan Africa, with nearly half of them occurring among women aged 15–19 years [2]. In Uganda, 25 percent of young women age 15–19 had begun childbearing in 2015 [3]. Adolescent childbearing (intended or not) has adverse effects at the individual, community, and societal level. Compared with their peers who delay childbearing, young women who have babies are less likely to finish high school, more likely to be poor as adults, and more liable to have kids who have poorer behavioral, educational, and health outcomes over the course of their lives than do children born to adult parents [4]. Babies born to teenage mothers also face a substantially higher risk of dying than those born to women aged 20 to 24 [5]. Also, adolescent pregnancies are more likely to be aborted [2]. In Africa, where pre-marital sex is not accepted, especially for young women, unintended pregnancies mostly happen outside marriage. This often implies secret, unsafe abortions under unhygienic conditions performed by people who lack the necessary skills and inplaces that do not meet minimal medical standards [6]. Teenage pregnancies could be avoided by using condoms or other. Most sexually active young people in

Uganda, however, do not use contraceptives: among those who are sexually active, 31% of those aged 12–18 years were not using any contraceptive method at their last sexual encounter [7]. If the majority of the pregnancies among teenagers are unwanted, this raises the question about why young people are not protecting themselves. Findings from studies conducted in sub-Saharan Africa indicate that young women's use of contraceptive methods is limited by several factors including violent and coercive sexual relationships, lack of knowledge,limited access to contraceptive methods, lack of control over contraception decisions, and concerns over the perceived side effects of family planning methods [8]. In Uganda, knowledge of the existence of contraceptives and where to obtain them seems to be high among the youth population [3]. However, this knowledge 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 [3]. 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 easilyavailable [9]. However, the situation in Uganda is not well researched [10]. The specific factors and beliefs that lead to contraceptive non-use remain obscure and up to date, evidence-based data on personal such as knowledge, attitudes, and skills) and environmental such as social and structural influences such as social support, reinforcements and access to contraceptives) determinants of teenage pregnancy are lacking. This is more so in rural areas like Kabarole district as most researchers tend to concentrate in urban areas. Thus, makes thus study important in exploring the factors contributing to teenage pregnancies. The study was carried out among teenage mothers attending antennal care at Fort Portal regional referral hospital in Kabarole district.

Despite the fact that teenage pregnancy in Uganda has been on a steady decline from 43% in1995 to 31% in 2002 and to 24.6% in 2006, the most recent [3] showed that the prevalence has increased to 25% [3]. This rate is unacceptably high. According to the [3], teenage child bearing is one of the main factors that explains the high fertility rates in Uganda and unless this is checked, the high maternal and child mortality rate and the negative impacts of teenage child bearing like school drop outs still threatens to undermine the remarkable improvement made by government and other stake holders to improve the household standardsof living for the vast majority of people in Uganda [3]. It also threatens to undermine the socio-economic development since the vast majority of young mothers miss out on opportunities to advance academically and therefore undermine their future competencies in contributing to development. This is because many of them drop out of school and hence fail to develop skills competencies for gainful engagement in economic activities. Interventions to curb the situation include the introduction of Universal Primary Education (UPE) in 1997, Universal Secondary Education (USE) in 2007 and the affirmative action at public universities, vocational and technical institutes to help prolong their stay in school. In addition, there was a directive by the President and Ministry of Education and Sports in 2002 that sex education should be taught in primary schools and during school assemblies and the launch of the Abstinence Till Marriage drive by the first lady respectively. In relation, the government put in place the program for Enhancing Adolescent Reproductive Life (PEARL) andthe provision of free condoms through the Ministry of Health. Other partners include the religious institutions especially the church, Straight Talk Foundation through its publications of "Young Talk" and "Straight Talk", Radio talk Shows, "Straight Talk Clubs in schools and communities, sensitization seminars and workshops, campaigns and movements among others, but the rates of teenage pregnancy show a slight decline [11]. All these interventions have yielded little progress which requires that a study be carried out to establish the actual

causes of teenage pregnancy so as to come up with appropriate interventions. It is thus paramount to carry out a study to establish the influencing teenage pregnancies. If this crisis is not checked, the future of the young generation is doomed. Fighting teenage pregnancy thus could be one way of saving a young and productive generation. However, this study will determine factors influencing teenage pregnancy among teenage mothers attending antenatal care at Fort Portal Regional Referral Hospital in Kabarole district.

## METHODOLOGY

### Study design

The researcher used a cross-sectional descriptive method of data collection because most of the research findings were reported in a descriptive statement and supplemented by figures and tables and the respective frequencies and percentages were calculated. A case study research design was used.

### Area of Study

The researcher collected data from the Fort Portal regional referral hospital in Kabarole District. The location is approximately 148 kilometres (92 mi) west of Mubende Regional Referral Hospital. It is a referral hospital for the districts of Bundibgyo, Kabarole, Kamwenge, Kasese, Ntoroko and Kyenjojo.

### Population of the study

The researcher was interested in teenage girls attending antenatal care at Fort Portal Regional Referral Hospital. The researcher also interfaced with health workers and community leaders in Kabarole District.

### Inclusion criteria:

Teenage girls below the age of 19 years attended antenatal care at Fort Portal Regional Referral Hospital at the time of the study.

### Exclusion criteria:

Teenage girls below the age of 19 years who were pregnant or had given birth and were attending antenatal care at Fort Portal Regional Referral Hospital at the time of the study but refused to consent or were in ill health. Pregnant mothers above 19 years old.

### Sample size determination.

The researcher sampled respondents who acted as the representatives of the entire population of teenage mothers. Key informants were also selected including local leaders and health workers.

The sample size was calculated using Keish Lesley Formula.$n= Z^2P (1-P) / E^2$

Z is the confidence interval, which is 1.96

E is the margin of error set at 5%

Confidence level 95%

P is the prevalence of teenage pregnancy. (The most recent Uganda Demographic and Health Survey 2016 (UDHS) showed that the prevalence has increased to 25% [3].

P= 25% = 0.25

$n= 1.96^2 \times 0.25(1-0.25)/ 0.05^2$

n= 288

### Sampling procedure

Simple random sampling was used to select teenage mothers. This was used to give all target populations equal chances of being selected thus reducing selection bias. Key informants were selected using purposive sampling to enable the researcher to select only those he thought were knowledgeable on the subject matter.

### Data sources, collection methods and instruments

### Sources of data

The researcher used primary data i.e. views directly from the field (respondents) who were either pregnant or young mothers at that time and the key informants. This was done through the one-to-one interviews that were held.

### Data Collection Methods

Semi-structured questionnaires were used to collect data from teenage mothers to give the researcher can collect both qualitative and quantitative data. Key Informant Interviews were used to collect data from key informants.

### Data collection procedure

The researcher got an introductory letter from the office of the Head, Department of Department at KIU which enabled her access and create rapport with the relevant officers and stakeholders. The cover letter explained the purpose of the study. The researcher sought permission from the hospital administration before accessing respondents. Informed consent from respondents was also requested.

**Data processing, analysis and interpretation**

The researcher cleaned the data right from the field by crosschecking all the questionnaires to ensure that all the required information had been captured. The researcher then used SPSS (Statistical Package for Social Scientists) to enter and analyze the data. The analyzed data was then processed using Microsoft Word, interpreted and presented using descriptive tables, for better understanding. The researcher then elaborated on the findings of the research in a research report.

**Quality Control**

To ensure the validity of the research and the results, appropriate collective measures were used to address the research tool. Irrelevant questions were avoided and only relevant questions were framed to capture relevant information.

**Data Reliability**

To ensure consistency of data, research assistants were given brief training and brief enlightenment about teenage pregnancy and its associated dangers to the life of a young mother.

**Data processing**

The data went through a cleaning and coding process before analysis. This involved field editing of questionnaires. After data collection, it was coded into the computer to eliminate certain errors that occurred during data entry.

**Ethical issues**

The researcher maintained a high sense of confidentiality of the information that was generated. All forms of support that were rendered to the researcher were acknowledged in the report. After obtaining the questionnaires, they were kept in the safe custody of the researcher [12]. No names of respondents were used in the study respondents were represented with numbers e.g. respondent number 3.

## RESULTS

**Demographic characteristics of the study**

Study findings in table one below indicate that majority of the respondents, 148 (51.4%) were in the age group of 17-19 years while the least, 51 (17.7%) were below 14 years of age. Most teenage girls/mothers, 210 (72.9%) were never married while the least,8 (2.8%) were divorced/single mothers. Most teenagers, 157 (54.5%) had attained Secondary level of education while the least, 61 (21.2%) had attained primary level of education. Most respondents, 99 (34.3%) were affiliated to Anglican religion while the least, 19 (6.6%) were born again Christians. Majority of the respondents, 174 (60.4%) resided in rural areas while the least 34 (11.8%) resided in peri-urban areas.

**Table 1 showing demographic characteristics of the study**

| Variable | Frequency (n=288) | Percentage (%) |
|---|---|---|
| **Age Group** | | |
| <14 years | 51 | 17.7 |
| 15-16 years | 89 | 30.9 |
| 17-19 years | 148 | 51.4 |
| **Marital status** | | |
| Never married | 210 | 72.9 |
| Married | 45 | 15.6 |
| Single Mother/ divorced | 8 | 2.8 |
| Cohabiting | 25 | 8.7 |
| **Educational level** | | |
| Primary | 61 | 21.2 |
| Secondary | 157 | 54.5 |
| Institution | 70 | 24.3 |
| **Religion** | | |
| Catholic | 81 | 28.1 |
| Anglican | 99 | 34.3 |
| Muslim | 54 | 18.7 |
| Born again Christians | 19 | 6.6 |
| Others (Faith of Unity) | 35 | 12.2 |
| **Residence** | | |
| Urban | 80 | 27.8 |
| Peri-Urban | 34 | 11.8 |
| Rural | 174 | 60.4 |

**Individual factors influencing teenage pregnancy among teenage mothers attending antenatal care at Fort portal regional referral hospital in Kabarole district.**

Study findings according to table 2 below indicated that 74 teenagers (25.7%), had ever been pregnant or given birth. Of these, 2 teenagers (0.7%) became pregnant below14 years, 26(9%) were in the age group of 14-16 years, and the most, 46(15.9%) were in the age group of 17-19 years. In this study, individual factors statistically significantly associated with teenage pregnancy in the model at 5% level were poor use of contraceptives and alcohol abuse. Teenage girls who never used any contraceptives were 6 times more likely to experience teenage pregnancy compared to teenage girls who used modern contraceptives (OR=6.01:95%CI, 3.922- 12.070: P=0.000). Also, teenage girls who relied on condoms as a form of contraceptive were 4 times more likely to experience teenage pregnancy compared to teenage girls who used oral pills (OR=4.29: 95%CI,1.731 -13.275: P=0.009). Injectable, Implants and IUDs were found to be more effective. Teenage girls who abused alcohol were 7 times more likely to experience teenage pregnancy compared to teenage girls who never took alcohol (OR=7.07:95%CI,1.15-23.73: P=0.015). In this Study, being in an intimate relationship was found not to be statistically significantly associated with teenage pregnancy in the model at 5% level. However, the study revealed that teenage girls who had been in an intimate relationship for more than 2 years were 1.9

times more likely to experience teenage pregnancy compared to teenage girls who had been in an intimate relationship for 1-2 years (OR=1.9: 95%CI,0.21-24.865: P=0.26).

**Table 2: showing Individual factors influencing teenage pregnancy among teenage mothersattending antenatal care at Fort portal regional referral hospital in Kabarole district.**

| Variable | Frequency (%) | Pregnancy n=74(25.7%) | No pregnancy n=214(74.3%) | OR (95% CI) | P-Values |
|---|---|---|---|---|---|
| **Know any modern contraceptives** | | | | | |
| Yes | 288(100%) | 74(25.7%) | 214(74.3%) | - | 0.99 |
| No | 0(0%) | 0(0%) | 0(0%) | Ref | |
| **Used any modern contraceptives** | | | | | |
| Yes | 158(54.9%) | 15 (9.5%) | 143 (90.5%) | Ref | - |
| No | 130(45.1%) | 59 (45.4%) | 71 (54.6%) | **6.01 (3.922-12.070)** | **0.000** |
| **Types of contraceptives used (n=158)** | | | | | |
| Injectable | 19(6.6%) | 0(0%) | 19 (100%) | 1 | 1 |
| Oral pills | 30(17.4%) | 1(3.3%) | 29 (96.7%) | Ref | - |
| Implants | 9(3.1%) | 0(0%) | 9(100%) | 1 | - |
| IUDs | 14(4.9%) | 0(0%) | 14(100%) | 1 | - |
| condoms | 122(49.3%) | 14(11.5%) | 108 (88.5%) | **4.29 (1.731 -13.275)** | **0.009** |
| **Alcohol Intake** | | | | | |
| Never | 59(20.5%) | 5(8.5%) | 54(91.5%) | Ref | - |
| Regularly | 71(24.6%) | 40 (56.3%) | 31 (43.7%) | **7.07(1.15-23.73)** | **0.015** |
| Rarely | 158(54.9%) | 29(18.4%) | 129 (81.6%) | 2.26(0.94-11.36) | 0.061 |
| **In intimate relationship** Yes | 197(68.4%) | 49 (24.9%) | 148 (75.1%) | 0.98(0.105-17.603) | 0. 89 |
| No | 91(31.6%) | 25 (27.5%) | 66 (72.5%) | Ref | |
| **Duration in intimate relationship(n=197)** | | | | | |
| < 1year | 60(20.8%) | 14 (23.3%) | 46 (76.7%) | 1.02(0.421- 25.384) | 0.997 |
| 1-2 years | 72(25%) | 15 (20.8%) | 57(79.2%) | Ref | |
| > 2 years | 65(22.6%) | 20 (30.8%) | 45 (69.2%) | 1.9 (0.21-24.865) | 0.26 |
| **Ever gotten pregnant** | | | | | |
| Yes | 74(25.7%) | 74(100%) | 0(0%) | - | - |
| No | 214(74.3%) | 0(0%) | 214(100%) | - | - |
| **Age of pregnancy** | | | | | |
| <14 years | 2(0.7%) | - | - | - | - |
| 14-16 years | 26(9%) | - | - | - | |
| 17-19 years | 46(15.9%) | - | - | - | - |

**Household based factors influencing teenage pregnancy among teenage mothersattending antenatal care at Fort Portal regional referral hospital in Kabarole district.**

According to table 3 below, in this study, household-based factors statistically significantlyassociated with teenage pregnancy in the model at 5% level were orphan hood, low-income status (poverty), lack of parental guidance and teenage girls not staying with their parents. Orphans were 2.7 times more likely to experience teenage pregnancy compared to teenage girlswho had both parents (OR=2.76: 95%CI, 2.05-16.95: P=0.031) Double orphans were 2 times more likely to experience teenage pregnancy compared to single orphans (OR=2.12: 95%CI, 0.84-37.05: P=0.001) Teenage girls who were not staying with their parent(s) were 2 times more likely to experience teenage pregnancy compared to teenage girls who stayed with their parent(s) (OR=2.35: 95%CI, 1.61-18.50: P=0.041) Teenage girls from poor households were 22 times more likely to experience teenage pregnancy compared to teenage girls from rich households (OR=22.1: 95%CI, 0.145-24.7: P=0.003) Teenage girls from middle income households were 9 times more likely to experience teenage pregnancy compared to teenage girls from rich households (OR=9.4: 95%CI,1.45-23.16: P=0.021) Teenage girls who lacked parental guidance were 2.6 times more likely to experience teenage pregnancy compared to teenage girls who received parental guidance(OR=2.65: 95%CI, 0.98 - 14.78: P=0.038).

**Table 3showing Household based factors influencing teenage pregnancy among teenage mothers attending antenatal care at Fort Portal regional referral hospital in Kabarole district.**

| Variable | Frequency (%) | Pregnancy n=74(25.7%) | No pregnancy n=214(74.3%) | OR (95% CI) | P-Values |
|---|---|---|---|---|---|
| **Have both parents** | | | | | |
| Yes | 194(67.4%) | 34(17.5%) | 160(82.5%) | ref | |
| No | 94(32.6%) | 40(42.6%) | 54(57.4%) | **2.76(2.05-16.95)** | **0.031** |
| **Type of orphan (n=94)** Single Orphan | 61(21.2%) | 20(32.8%) | 41(67.2%) | ref | |
| Double orphan | 33(11.4%) | 20(60.6%) | 13(39.4%) | **2.12(0.84-37.05)** | **0.001** |
| **Stay with parent(s)** | | | | | |
| Yes | 201(69.8%) | 40(19.9%) | 161(80.1%) | ref | |
| No | 87(30.2%) | 34(39.1%) | 53(60.9%) | **2.35(1.61-18.50)** | **0.041** |
| **History of domestic or sexual violence** | | | | | |
| Yes | 76(26.4%) | 29(38.2%) | 47(61.8%) | 1.84(0.452-19.24) | 0.490 |
| No | 212(73.6%) | 45(21.2%) | 167(78.8%) | Ref | |
| **Income status** | | | | | |
| Poor | 112(38.9%) | 48 (42.9%) | 64(57.1%) | **22.1(0.145-24.7)** | **0.003** |
| Medium income | 128(44.4%) | 25 (19.5%) | 103(80.5%) | **9.4(1.45-23.16)** | **0.021** |
| Rich | 48(16.7%) | 1 (2.1%) | 47(97.9) | Ref | |
| **Parental guidance** | | | | | |
| Yes | 186(64.6%) | 32 (17.2%) | 154 (82.7%) | Ref | |
| No | 102(35.4%) | 42 (41.2%) | 60 (58.8%) | **2.65 (0.98 -14.78)** | **0.038** |

**Community based factors influencing teenage pregnancy among teenage mothers attending antenatal care at Fort Portal regional referral hospital in Kabarole district.**

Study findings according to table 4 below indicate that Community based factors statistically significantly associated with teenage pregnancy among teenage mothers attending antenatal care at Fort Portal regional referral hospital in Kabarole district in the model at 5% level were peer influence, watching pornographic content, limited access to Reproductive health services and cultural norms. Teenage girls who had sex due to peer influence were 2 times more likely to experience teenage pregnancy compared to teenage girls who didn't (OR=2.01: 95%CI, 0 .633-11.39): P=0.043) Teenage girls who watched pornographic videos were 5 times more likely to experience teenage pregnancy compared to teenage girls who didn't (OR=5.73: 95%CI, 4.105-12.603: P=0.002) Teenage girls who lacked access to Reproductive health services were 1.7 times more likely to experience teenage pregnancy compared to teenage girls who had access to Reproductive health services (OR=1.73: 95%CI,1.125-18.603: P=0.041) Teenage girls were asked Cultural norms in their communities that led to teenage pregnancies, 141(48.9%) suggested early marriages, 38(13.2%) stated arranged marriages and 47(16.3%) stated forced sex with witch doctors in guise of healing certain diseases. Teenage girls who had such cultural norms in their communities were 4 times more likely to experience teenagepregnancy compared to teenage girls who lived in communities with no such cultural norms (OR=4.41: 95%CI,0.51-8.59: P=0.009).

## DISCUSSION

**Individual factors influencing teenage pregnancy among teenage mothers attending antenatal care at Fort portal regional referral hospital in Kabarole district.**

Teenage girls who never used any contraceptives were 6 times more likely to experience teenage pregnancy compared to teenage girls who used modern contraceptives. Lack of sufficient knowledge of the preventive measures, not using birth control devices or 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 [8]. In another study, according to [9], lack of self-esteem and self-confidence leads teenagers to consent to unprotected sex. Most often, the young woman fears that she willbe rejected by her partner if she refuses to have unprotected sex or insists that he uses a condom. However, it should not be forgotten that in some cases, it may be the young man who is afraid to bring up the subject of contraception with his partner. 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 todeal with this pressure or to say "no". Fear of asserting oneself and fear of rejection is very common among young people [11].

Teenage girls who abused alcohol were 7 times more likely to experience teenage pregnancy compared to teenage girls who never took alcohol. Lack of discipline and control due to alcohol and substance abuse accompanied by unrestricted interaction with the opposite sex can ignite the sparks of lust and passion in youngsters very easily ultimately leading to early sex and teenage pregnancy. In a related study, it was revealed that teenage pregnancy and birth is often associated with alcohol and drugs. Some studies show that teenage drinking, alcohol and substance usage/abuse can cause an unexpected pregnancy, according to the website Love to Know. Many teens experiment with drugs and alcohol. Drinking lowers a teen's ability to control her impulses thus contributing to 75% of pregnancies that occur between the ages of 14 and 21 [11].

Teenage girls who had been in an intimate relationship for more than 2 years were 1.9 times more likely to experience teenage pregnancy compared to teenage girls who had been in an intimate relationship for 1-2 years. This

is because at times, being in long term relationshipswhen still young also leads to pregnancy as precautions may not be taken in such a situation. A study by [9] revealed similar findings. This is because it is usually believed that there's a bond and sense of trust built between the partners thus no need to keep on using protective measures especially condoms (Apanga, and Adam, 2015).

**Household based factors influencing teenage pregnancy among teenage mothersattending antenatal care at Fort Portal regional referral hospital in Kabarole district.**

Orphans were 2.7 times more likely to experience teenage pregnancy compared to teenage girls who had both parents. Double orphans were 2 times more likely to experience teenage pregnancycompared to single orphans. This is attributed tolack 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 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 [13]. Teenage girls who were not staying with their parent(s) were 2 times more likely to experience teenage pregnancy compared to teenage girls who stayed with their parent(s). This is because when a teen does not feel that she can talk to her parents about sex either because they forbid sextalk or because they are not around, she will likely turn to friends for direction on whether or not to have sex, resulting in misinformation and possible teen pregnancy. Teen girls with absentee parents are more likely to get pregnant if they have limited or no guidance from their parents. 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 [9]. Teenage girls from poor households were 22 times more likely to experience teenage pregnancy compared to teenage girls from rich households. A high level of poverty for instance financial constraints renders some young girls liable to exploitation by older men. Girls who date older men are more likely to become pregnant before they attain womanhood. The social economic factor is clearly spelled out as teenage girls who belong to poor families are more likely to become pregnant. In related studies, 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 [14]. Teenage girls who lacked parental guidance were 2.6 times more likely to experience teenage pregnancy compared to teenage girls who received parental guidance. It is common in Uganda for most parents to evade 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. In a related study by [15], it was revealed that lack of awareness about the causes and effects of teenage pregnancy is more often than not, a result of lack of proper communication between teenagers and their parents. Therefore, 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 [16].

**Community based factors influencing teenage pregnancy among teenage mothersattending antenatal care at Fort Portal regional referral hospital in Kabarole district.**

28.8% of the teenagers had had sex due to peer influence. Teenage girls who had sex due to peer influence were 2 times more likely to experience teenage pregnancy compared to teenage girls who didn't. During adolescence, teenagers often feel pressure to make friends and fit in with their peers. 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. Teenagers have sex as a way to appear cool and sophisticated but, in some cases, the end result is an unplanned teen pregnancy. The Kaiser Family Foundation states that more than 29% of pregnant teens reported that they felt pressured to have sex and 33 percent of pregnant teens stated that they felt that they were not ready for a sexual relationship but proceeded anyway because they feared ridicule or rejection [17]. Teenage girls who watched pornographic videos were 5 times more likely to experience teenage pregnancy compared to teenage girls who didn't. The movie industry and the media contribute toteenage pregnancy by glamorizing teen pregnancy in news stories and movies. Movies that depict teen pregnancy as something to be desired encourage teens to engage in reckless sexual activity. During adolescence, teens become more focused on their appearance and how their peers perceive them. They want to be seen as part of the group, so if teen pregnancy is viewed as acceptable in their school or amongst their friends, they may seek to become pregnant as a wayto gain social acceptance [9].

Teenage girls who lacked access to Reproductive health services were 1.7 times more likely to experience teenage pregnancy compared to teenage girls who had access to Reproductive health services. Shortages in condoms and other reproductive health services were identified as another cause of teenage pregnancies. Lack of such services hinder the education of teenage girls about the dangers of early pregnancies and how to avoid them. According to a Joint Action Plan by the Ugandan Government and the United Nations Population Fund (UNFPA), only 38% of young women and 55% of young men in Uganda say they used a condom the last time they had sex, according to UNICEF's most recent statistics [18] On cultural norms in communities that lead to teenage pregnancies, 48.9% confirmed early marriages, 13.2% stated arranged marriages and 16.3% stated forced sex with witch doctors in guise of healing certain diseases. Teenage girls who had such cultural norms in their communities were 4 times more likely to experience teenage pregnancy compared to teenage girls who lived in communities with no such cultural norms. In a 2014 study by Cho and Lee, it was revealed that some cultural norms have led to teenage pregnancy. Many societies still look at girls as sources of wealth and they end up forcing them into early marriages. Some people have perceptions that sleeping with virgin girls help heal certain diseases such as HIV which leads to defilements [19]-[24].

## CONCLUSION

Not using contraception, regularly taking alcohol were the most common individual factors influencing teenage pregnancy. Being an orphan, lack of parental guidance and low socio-economic status were the household based factors that strongly and importantly influenced teenage pregnancy. Peer influence, watching pornographic videos, lack of access of reproductive health services and cultural norms were the most influencing factors in the community.

### Recommendations

The incidence of teenage pregnancy was as high as (25.7%), poor use of contraceptives and alcohol abuse, poverty, lack of parental guidance, limited access to Reproductive health services and early marriages contributed to this high incidence. There is need to improve specific knowledge about reproductive health on a wide range and address related concerns of teenage pregnancies. The government of Uganda needs to establish more Centers especially in rural areasso as to curb the problem of limited access to Reproductive health services. The Government of Uganda needs to regulate alcohol and drug abuse among teenagers by limiting access to alcohol and drugs.

## REFERENCES

1. Dick, B. & Ferguson, B. J. (2015) Health for the World's Adolescents: A Second Chance in the Second Decade, Journal of Adolescent Health, Vol. 56(1): 3-6, DOI:http://dx.doi.org/10.1016/j.jadohealth.2014.10.260
2. UNFPA (2013). Motherhood in childhood: facing the challenge of adolescent pregnancy. New York: United Nations Population Fund
3. Uganda Bureau of Statistics - UBOS, ICF. Uganda Demographic and Health Survey 2016. Kampala: UBOS and ICF; 2018.
4. Cook, S. M. C., & Cameron, S. T. (2015). Social Issues of Teenage Pregnancy." Obstetrics, Gynaecology & Reproductive Medicine 25 (9): 243–248.
5. WHO(2014).Adolescentpregnancy.http://www.who.int/mediacentre/factsheets/fs364/en/. Accessed 13 May 2017.
6. WHO (World Health Organisation). 2011. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008. Geneva: WHO.
7. Doku, D. (2012). Substance Use and Risky Sexual Behaviours among Sexually Experienced GhanaianYouth. BMC Public Health 12: 1220.
8. Macleod, C. I., & Tracey, T. (2010). A Decade Later: Follow-up Review of South African Research on the Consequences of and Contributory Factors in Teen-Aged Pregnancy. South African Journal of Psychology, 40 (1): 18–31.
9. Apanga, P. A., & Adam, M. A. (2015). Factors Influencing the Uptake of Family Planning Services in theTalensi District, Ghana. Pan African Medical Journal, 20 (12): 1–9.
10. Val Hyginus Udoka Eze, Chidinma Esther Eze, Asiati Mbabazi, Ugwu Chinyere N, Ugwu Okechukwu Paul-Chima, Ogenyi, Fabian Chukwudi, Ugwu Jovita Nnenna, Alum Esther Ugo and Obeagu Emmanuel I. (2023). Qualities and Characteristics of a Good Scientific Research Writing; Step-by-Step Approaches. IAA Journal of Applied Sciences 9(2):71-76. https://www.iaajournals.org/wp-content/uploads/2023/08/IAA-JAS-9271-76-2023.docx.pdf
11. Bastien, S., Kajula, L. J., & Muhwezi, W. W. (2011). A Review of Studies of Parent-Child Communication about Sexuality and HIV/AIDS in Sub-Saharan Africa. Reproductive Health 8 (1):103.
12. Ugwu Chinyere Nneoma, Eze Val Hyginus Udoka, Ugwu Jovita Nnenna, Ogenyi Fabian Chukwudi and Ugwu Okechukwu Paul-Chima (2023). Ethical Publication Issues in the Collection and Analysis of Research Data. Newport International Journal Of Scientific And Experimental Sciences (NIJSES) 3(2): 132-140. https://nijournals.org/wp-content/uploads/2023/07/NIJSES-32-132-140-2023.pdf
13. Manu, A. A., Mba, C. J., Asare, G. Q., Odoi-Agyarko, K., & Asante, R. K. O. (2015). Parent– Child Communication about Sexual and Reproductive Health: Evidence from the BrongAhafo Region, Ghana. Reproductive Health 12 (1): 1–13.
14. Bhana, D., & Pattman, R. (2011). Girls Want Money, Boys Want Virgins: The Materiality of Love amongst South African Township Youth in the Context of HIV and AIDS. Culture, Health & Sexuality, 13 (8):961–972.
15. Marcotte, D. E. (2013). High School Dropout and Teen Childbearing. Economics of Education Review 34:258–268.
16. Wood, K., & Jewkes, R. (2006). Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. Reproductive Health Matters 14 (27): 109–118.
17. UNICEF (2008). Fact Sheet Young People and Family Planning. United Nations Children's Fund. http://www.unicef.org/malaysia/Teenage_Pregnancies_-_Overview.pdf. Accessed 22 June 2017.
18. Adjei, D., Sarfo, J. O., Asiedu, M., &

Sarfo, I. A. (2014). Social Cognitive Factors Affecting Contraceptive Usage: A Case of Unmet Needs in Ghana. European Scientific Journal 10 (15): 84–93.

19. Cho, J. Y., & Lee, E. (2014). Reducing Confusion about Grounded Theory and Qualitative Content Analysis: Similarities and Differences. The Qualitative Report 19 (64): 1–20.
20. Singh, D., Lample, M., & Earnest, J. (2014). The involvement in maternal health care. Uganda. Reprod Health.
21. Ivan, B., Andrew, T., Sunday, A. (2023). Intentional Behaviors that Affect Utilization of Family Planning Services among HIV-Positive Women Attending Antiretroviral Therapy Clinics in Bushenyi District- Uganda. INOSR Experimental Sciences. 10 (1), 61-85.
22. Jackson, A. (2023). Evaluation of the Factors that Affect Family Planning Methods in Clients Attending Maternal Child Health Services at Kyabugimbi Health Centre IV, Bushenyi District, Uganda. IDOSR Journal of Science and Technology. 9(1), 53-65.
23. Mbambu, M. J. (2023). Evaluation of the knowledge, attitude and practice among women attending family planning at Bwera general Hospital. INOSR Experimental Sciences, 11(1), 1-16.
24. Pennina, Kiden. (2023). Evaluation of Factors that Contribute to Low Utilization of Methods for Family Planning Among Adolescents at Adjumani Hospital, Adjumani District. IDOSR Journal of Sci., 9, 12-25.

**CITE AS: Apili Everlyne (2023). Influential Elements Impacting Adolescent Pregnancy in Teen Mothers Seeking Antenatal Care at Fort Portal Regional Referral Hospital, Kabarole District. INOSR APPLIED SCIENCES 11(1):13-24. https://doi.org/10.59298/INOSRAS/2023/2.6.4000**