TEENAGER PREGNANCIES AND RESPONSE TO COMPREHENSIVE HEALTH CARE SERVICES: A CASE STUDY OF MAKINDYE DIVISION, KAMPALA

BY

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SEPTEMBER, 2016

DECLARATION

"I declare that this dissertation is my original work and has never been presented for a degree or any other academic award in any university or institution of learning".

Amundala Asumani

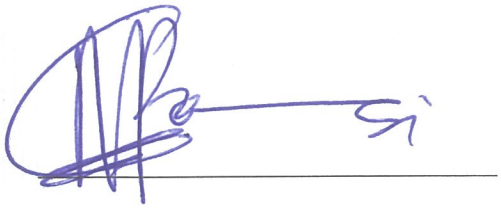
Name and Signature of Candidate

6th oct 2016

Date

APPROVAL

"I affirm that the work presented in this dissertation was carried out by the candidate under our supervision".



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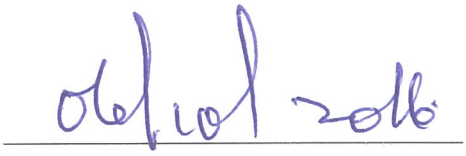

Date

DEDICATION

This research report is dedicated to my dear parents without whose help; I would not have produced this piece of work. May the almighty bless you abundantly.

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It has been a struggle finishing this work, there has been great support from different individuals and institutions without which it wouldn't have been possible. It is therefore, essential to recognize their contribution.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
CEDAW:	Convention on the Elimination of All forms of Discrimination Against Women
COFAPRI:	Congolese Females Action for Promoting Rights and Development
DRC:	The Democratic Republic of the Congo
FAO:	Food and Agricultural Organization of the United Nations.
GBV:	Gender Based Violence
GLR:	Great Lakes Region
HIV:	Human Immune Deficiency Virus
HRW:	Human Rights Watch
ICRW:	The International Centre for Research on Women
IRC:	International Rescue Committee
IVAWA:	International Violence Against Woman Act
MONUC:	Mission des Nations Unies au Congo (United Nations Mission in the Congo)
NGOs:	Non-Governmental Organisations
PTSD:	Posttraumatic Stress Disorder
STDs:	Sexually Transmitted Diseases
SWFW:	Safe World For Women
UN:	United Nations

UNAIDS:	United Nations programme on AIDS.
UNDP:	The United Nations Development Programme
UNFPA:	The United Nations Population Fund
UNICEF:	The United Nations Children's Fund
UNIFEM:	United Nations Development Fund for Women
USA:	The United States of America
VAW:	Violence Against Women
WFP:	World Food Programme
WHO:	World Health Organization
WPC:	Women Power Connect
WTBTS:	Watch Tower Bible Tract Society

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ABSTRACT

The topic of the study was teenager pregnancies and response to comprehensive health care services in Makindye division, Kampala. The problem was low levels of teenage response to comprehensive health care services in Makindye division, Kampala. The objectives of the study were: to establish the extent of teenage pregnancies, causes and pregnancy outcomes; to establish the level of teenage response to comprehensive health care services and to identify teenage pregnancy prevention measures in Makindye division, Kampala. This research employed descriptive designs such as cross sectional design and also used case study design. The findings revealed the following: From the findings of the study, on respondents' background information the researcher concluded From the findings of the study, on respondents' background information the researcher concluded that majority of respondents in this sample were in their early adulthood age, that is, 18-30 years, women in Makindye division, Kampala are moderately educated, most of the women in Makindye division, Kampala. It can also be concluded tha' increased number of teenagers in Makindye division, Kampala do not respond to comprehensive health care services.

Therefore that encouraging and emphasizing maternal education is a major prevention measure to teenage pregnancies followed by encouraging women to engage in various activities as their occupations. It can be concluded that concluded that majority of respondents in this sample were in their early adulthood age, that is, 18-30 years, women in Makindye division, Kampala are moderately educated, most of the women in Makindye division, Kampala, It can also be concluded that there is increased number of teenage pregnancies among women in Makindye division, Kampala. In the increased number of teenagers, Kampala do not respond to comprehensive health care services. And that encouraging and emphasizing maternal education is a major prevention measure to teenage pregnancies followed by encouraging women to engage in various activities as their occupations. The researcher recommended to the government through the state and division that it should encourage and emphasize maternal education also to the division that it should encourage women to get pregnant at a mature maternal age, also to the community mostly women that they should engage in various activities as their occupations such as small scale businesses (restaurants, mobile money shops, retail shops among others) which can act as source of income, also to the government to come up with teenage pregnancy prevention team in the division and that establishing a teen pregnancy coalition-which is a state wide organization which participates in multiple activities in teen pregnancy prevention.

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter contains the back ground of the study, problem statement, the purpose of the study, objectives of the study, research questions, research hypothesis, scope of the study and the significance of the study

1.1 Background of the study

The decade has seen a similar broadening of policy focus designed to meet the needs of pregnant teens and teen parents. The initial programs in the seventies targeting pregnant teenagers and teen mothers focused primarily upon their health needs, assuring adequate pre- and postnatal care and pediatric services for the young woman and her infant.

By the late seventies, in growing recognition of this population's multiple, interrelated needs, teen pregnancy programs offered directly, or through referral, a much more comprehensive package of services to include: continued schooling, income support, parenting education, vocational and psychological counselling, family planning (to prevent second births), family counselling, transportation, nutrition services, child care and, sometimes, housing.

In the early eighties, Conservatives added an emphasis on adoption counselling to this broad agenda. As a result, "comprehensiveness" and linkages with other services became the watchwords for successful teen parent programs. And case management became the "glue" that was designed to put all the pieces together and ensure the teen client did not get lost in the maze. These community-based programs were funded through multiple public and private sources and were characterized by flux and instability as a result.

The majority were targeted on low-income communities with high rates of teen pregnancy and childbearing, initially in urban areas although increasingly programs began to be set up in rural areas as well. By the mid-eighties, many programs were striving to incorporate new components and emphases.

Many attempted, in an ad hoc fashion, to reach out to include the male partner of their teen clients, usually, a young man with multiple needs for services himself. And many programs began to include various family involvement strategies, working directly with the teen girl's family—the baby's grandparents—with whom she usually lived and remained dependent upon, in order to maximize their support.

By the late eighties, new research findings emphasized the fact that teen parents are those at greatest risk of long-term dependency on public welfare assistance. These findings combined with a change in public values and attitudes towards maternal employment and public dependency is causing a major shift in policy strategy towards the majority of teenage mothers who receive public assistance.

The Family Support Act of 1988 requires AFDC teen mothers who have not completed high school to enroll in continued education and training, and all teen mothers to enroll in the Job Opportunities and Basic Skills (JOBS) program, no matter how young her baby (as long as appropriate child care was available, etc.). (For details of the Act's requirements and various support services, see Ooms, Golonka and Herendeen, 1990.) Other older welfare mothers are exempt from required JOBS participation if they have a child under three years of age, or at state option, under one year. The Family Support Act also places more emphasis on the unwed fathers' financial responsibility in two ways. First, through strengthening child support collection procedures and second, it hopes to increase rates of paternity establishment by requiring that both parents social security numbers be registered at the time of the child's birth. Many questions remain about the extent to which states will in fact focus on the teen parent portion of the welfare population as they implement the Family Support Act and about the ability of welfare agencies to work collaboratively with education agencies. (These issues will be the subject of a seminar to be held later in the year.)

The Department for Public Health (DPH), Division of Women's Health (DWH) in collaboration with the Maternal Child Health (MCH) Division and the Kentucky Department of Education (KDE), Coordinated School Health (CSH) Program assessed the problem of teen pregnancy in 2009 and 2010. Eleven public forums were held across the state in the summer of 2009. These forums were conduct by MCH and were done to identify public health needs in developing countries.

The attendees of the forums included area public health department staff, local physicians and dentists, local healthcare workers, area business people, area clergy, teachers, Family Resource/Youth Service Center (FRYSC) staff from public schools and any other interested community partners.

Topics of discussion included oral health, tobacco use, prenatal care and breastfeeding, teen pregnancy, substance abuse, health care access and insurance, obesity and nutrition, and any other concern identified by the local community of a particular forum. All forums included attendees" participation in prioritizing the MCH health concerns in their particular locale

Teen pregnancy was the number one identified local problem in nine of the forums and the number two local problem in the other two forums.

MCH surveyed the clients in their local health departments/districts through the fall of 2009 regarding the health concerns that they have for themselves and their families. Results of those surveys showed that their number one adolescent health concern is teen pregnancy. A Sexuality Education Survey was sent to 521 middle and high schools in the 170 public school districts in the Commonwealth of Kentucky in October, 2009.

This was designed, administered and evaluated by the Adolescent Health Initiatives Coordinator with support from the CSH Data team, which includes Kentucky Department of Education (KDE) staff. Two hundred-ninety-six schools (56%) from 137 districts (81%) responded. Significant findings report that the majority of responding schools teach some form of sexuality education in 7th, 8th, and 9th grade. Abstinence only or abstinence plus the use of condoms for disease control are taught in 54% of responding schools.

Comprehensive sexuality education - defined as skills to communicate effectively and make responsible decisions, abstinence from sexual activity as a responsible method or preventing pregnancy and disease, forms of contraception, and prevention and treatment of sexually transmitted infections (STI) including HIV- is taught in 33% of the responding schools. Six percent of the schools reported teaching only about STI/HIV and 7% reported that they do not teach any form of sexuality education. Sexuality education is listed in the KDE required program of studies. Local control is given to individual schools to determine their interpretation of that mandate, curriculum and content.

Teen Impact Groups, a focus group format, were conducted in nine high schools across the Commonwealth by the Adolescent Health Initiative Coordinator and staff of the DWH in early 2010. Participants were students age 16 and older.

Impact groups were conducted in urban, rural, alternative, and suburban schools. Mirroring the questions asked at the MCH Public Health Forums, the groups were asked to respond to four questions: 1) Why are teens getting pregnant and what are the problems that surround this issue? 2) What programs and services are in place at this time in your area that addresses teen pregnancy and prevention? 3) How would you fix the problem of teen pregnancy? 4) What are the barriers that prevent programs from occurring and keep teens from using these programs?

A wealth of knowledge was gained from the teen participants of these groups and it has greatly impacted the direction of the teen pregnancy prevention program in countries. Significantly, the teens reported that the want sexuality education every year or every other year to reinforce what they know and they want their parents to be better equipped to communicate with them. Secondly, the teens reported that they want more to do with their time and that they want to be involved in their communities.

The groups also stated that they want more „one on one" time with adults and that they need adult mentors who care. They stated that barriers to teen pregnancy prevention programs include a lack of time, a lack of funding, and a lack of volunteers and transportation. The use of 2008 public funds was assessed in the spring of 2011 by the DWH.

It was estimated that teen pregnancy cost Kentucky taxpayers at least $132 million in 2008. The source of these expenses is Medicaid expenditures for prenatal care, delivery, postpartum care and infant care for one year after birth, housing allowances, WIC (Women, Infant, and Children Program) expenditures, food stamps for teen mother and baby for one year, lost tax revenues, child care costs, and estimated yearly operational costs for special school programs addressing pregnant and parenting students.

These costs do not include lost revenue to public schools for missing school days and dropping out of school that often occur with pregnancy.

The teenage pregnancies has been rampant in Kampala majorly in Makindye division and there is low levels of teenage response to comprehensive health care services. This as a result has affected the health of both the teenage mothers and the children both during pregnancy, during time of birth and after birth. There is increasing rate of morbidity, maternal mortality, low birth weight of the children and high rate of children death during time of birth, (MP Makindye East, 2015). Therefore, there is need to explore the factors for teenage pregnancies and suggest measures to reduce the cases of teenage pregnancies.

1.2 Problem statement

Teenage pregnancies and child bearing which is detrimental to the health of the mother and child, is a common public health problem affecting most countries both developed and developing. The problem for this study is low response of teenage pregnant women to comprehensive health care services in Makindye division, Kampala, (Report from, MP Makindye East, 2015). Uganda is one of the countries with the highest pregnancies in the world, which was recorded at 43% 1n 1995. This has since reduced to 31% 1n 2000/2001 and 25% in 2006 (UDHS) and finally 24% in 2011.

The continuous low response of teenage pregnant women to comprehensive health care services will affect the teenage mothers and the child both during pregnancy, at birth and after birth.

In order to help solve the problem, factors responsible for teenage pregnancies need to be explored, hence the need for the study. This study therefore, is intended to assess how teenagers respond to comprehensive health care services and the effects to the teenage mothers and children during and after birth.

1.3 The purpose of the study

The purpose of this study was to assess how teenagers respond to comprehensive health care services in Makindye division, Kampala.

1.4 The objectives of the study

The following were the specific objectives under which the study was carried out:

1. To establish the extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala
2. To establish the level of teenage response to comprehensive health care services in Makindye division, Kampala.
3. To identify teenage pregnancy prevention measures in Makindye division, Kampala.

1.5 The research questions

1. What is the extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala?
2. What is the level of teenage response to comprehensive health care services in Makindye division, Kampala?
3. What are teenage pregnancy prevention measures in Makindye division, Kampala?

1.6 The scope of the study

1.6.1 Geographical scope

The study was carried out in Makindye division Kampala. The study concentrated on those areas around Makindye barracks.

1.6.2 Content scope

The study concentrated on teenage pregnancies and their response to comprehensive health care services. The causes of teenage pregnancies were looked at, the outcomes and the preventive measures for teenage pregnancies were explored.

1.6.3 Time scope

The study was conducted for a period of five months, that is, from March, 2016 to July 2016. That was from proposal writing, data collection, report or dissertation writing up to submission of the final work.

1.7 Significance of the study

The study can be useful in the following ways:

It can be useful to Makindye division in identifying the teenage pregnancies in the division and compare it with the rest of the country.

It is expected that the findings of this study can be useful to Makindye division in Kampala on how to effectively provide comprehensive health care services to the teenage pregnancies so as to improve on their health standards.

The findings of this study can be useful to the government of Uganda especially the federal government in that, it can help in identify in the key causes of teenage pregnancies in Makindye division, Kampala.

The study findings can also benefit the other members of Makindye division such as the local people and other individuals who are concerned with teenage pregnancy issues.

The findings are also important to the health workers because it has established strategies to reduce on teenage pregnancies in Makindye division Kampala.

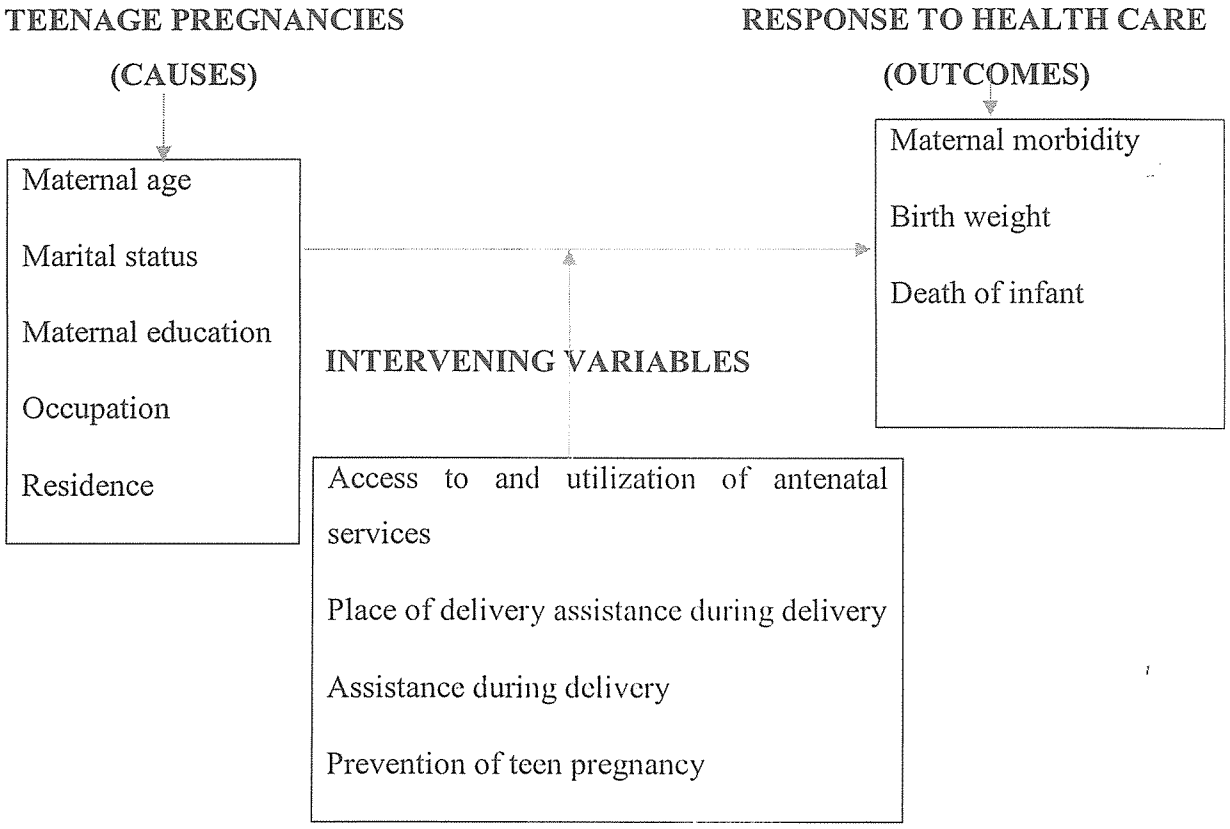
The researcher expects that information can be useful in understanding the Teenage pregnancies and the response to comprehensive health care services.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This was a discussion of the existing literature and serves to give insight to the researcher about the topic under investigation. The literature review in this chapter was looked at in line with the objectives of the study, that is, objective by objective.

2.1 Conceptual framework



Source: Coates and Maxwell, (2006).

The figure 1: is the conceptual framework of the study which shows the independent and dependent variables in the topic under investigation and the effects the independent variable has on dependent variable. The independent variable is teenage pregnancies while the dependent variable is response to comprehensive health care services in Makindye division, Kampala. The teenage pregnancies are caused by factors such as maternal age, marital status, maternal education, occupation and residence. The outcomes of teenage pregnancies on response to comprehensive health care services are maternal morbidity, birth weight and death of infant. The other factors that may lead to effects to teenagers are access to and utilization of antenatal services, place of delivery, assistance during delivery, and prevention of teen pregnancies.

2.1 The extent teenage pregnancies, causes and pregnancy outcomes

2.1.1Teenage pregnancies

Teenage pregnancies and child bearing is a common phenomenon all over the world carrying with it the risk of increased morbidity and mortality to the mother and the child. It is a problem that affects nearly every society including both developed and developing countries. Teenage pregnancy prevalence in Uganda has of recent shown a down trend.

Teenage pregnancy prevalence in Uganda has of recent shown a down trend from a record 43% in 1995 to 31% in 2002 to 25% in 2006 to 24% in 2011 (UBOS and Marco, 2002, 2011). Teenage pregnancy is singled out because of its association with higher morbidity and mortality for both the mother and the child. In addition to the physiological risc under the cunent school practice, pregnant girls have to terminate their education, which may indirectly affect the health of the mother and the child through loss of socio-economic opportunities. According to the 2000/01 UDHS, the percentage of young mothers who have ever been pregnant increases with age, from 32% for 15 to 19 year-olds to 88% for the 20-24 year olds. By 2001, 31% of the teenagers had begun childbearing with 26% having had a baby. Rural teenage women are more likely to start parenthood earlier than their urban counterparts, 34% and 23% respectively in 2001/2, and 20% and 26% in 2006, and 24% in 2011. In Uganda, teenage pregnancy also varies greatly with the woman's education, being higher among the less educated (at 50% in 2011). According to the 2011 UDHS report, teenage pregnancy was also highest among the poor (4 1%) Adolescent pregnancy in Kampala district several studies conducted in the district indicate high levels of adolescent pregnancies and early marriages in the district (Sekiwunga et al, 2003, Katahoire 1998). Teenage pregnancy in center region and in Kampala district was higher

Than the national figure at 37% (against 31% national in 2000/01 -2000/01 UDHS), being one of the highest in the country. Although, the rate reduced to 31% (2011 UDHS), the number of teen age girls exposed to the problems of early pregnancies and childbirth in this district is still high compared to other districts in Uganda. This is why this study was undertaken to find out the long term effect of these pregnancies to young mothers.

2.1.2 Causes of teenage pregnancies

2.1.2.1 Maternal age

The age of the mothers at which she deliveries her first child is very important since in most cases it influences the pregnancy outcomes. Several studies (Sirnoes at al 2003; De Silva et al 20003) have pointed out that teenagers aged 18 years and below were observed to have the

highest proportions of low birth weight, pre-term deliveries and infant mortality rates due to their biological immaturity.

Oboro et al (2003) have further argued that teenage mothers of 15 years and below were at higher risk of poor pregnancy outcomes, such as being anemic, premature labor, low birth weight and operation deliveries than their counterparts who were aged 16 to 19 years. However, there is a serious debate whether age per se is responsible for the poor pregnancy outcomes.

Scholars such as Negussie and Obare (2003) in their study on pregnancy and child health Outcomes among adolescents in Ethiopia have argued that studies that emphases maternal age in influencing teenage pregnancies are Hospital-based, which he refers too as employing less-rigorous analytical methods.

Negussie and Obare also concurs with Oboro that the independent effect of maternal age on the frequency of preterm delivery, low birth weight and neonatal mortality was only significant as age if first childbirth falls below 16 years of age.

Moore et al (1995) have concluded that early childbearing and poor health outcomes is due not to age, but rather to the numerous risk factors associated with being young such as inadequate prenatal care and nutrition.

Scholars like Gordon et al (2005) have further argued that first teenage births are not independently associated with an increased risk of adverse pregnancy outcomes but that it was the second teenage births that are associated with an ahnost threefold risk of preterm delivery, still birth and other STDs. There is scanty infonnation on maternal age and teenage pregnancies and child birth in Uganda, however, it is indicated that children born to very young women suffer higher mortality rates than those born to older women (UBOS and ORC Marco, 2001) and infant mortality rates were observed to be higher at 105 deaths per 1,000 births under 20 years compared to 82 per 1,000 for births to women aged 20 to 29.

2.1.2.2 Marital status

In a study in Southern Nyanza Kenya, Magadi (2004) pointed out that pregnancies outside marriage are siilficantly more likely to result in pregnancy waste, such as abortion or stillbirth than those in marriage.

This view is also supported by Reichman et al (1997) who said that other social factors associated with poor birth outcomes included unmarried status among others. In Uganda, young mothers are more likely to be unmarried and less educated both of which tend to result

in fewer financial resources which could lead to poorer health care for their children (ORC Marco, 2001).

However scholars such as Ventura et al (1999) found little difference in outcomes for teenage mothers who were married at the time of delivery and those not married.

2.1.2.3 Maternal education

Maternal education is associated with pregnancy outcomes in that the higher the level of educational attainment of the teenage mother, the less risk of having poor pregnancy outcome. Education is believed to promote a woman's knowledge and skills that enable her overcome some of the negative physiological effects associated with maternal factors. This is through enhanced utilization of health services, better hygienic practices and ability to provide adequate health care and challenging her traditional notions of disease (UBOS, 1995).

Gebremariam (2005) found out that mother's education, among other factors was stro1:gly and significantly associated with prenatal care and attended delivery.

Negussie et al (ibid) also noted that in poor countries such as Ethiopia, factors like education greatly influenced the disparity in service utilization and hence the probability of survival for children born to teenage and adult mothers.

This has also been observed to be true of Uganda. There are no divergent views as regards to education and pregnancy outcomes.

2.1.2.4 Residence/location

Residence as a risk factor in teenage pregnancy has been cited by several scholars including Mahy (2003), Marcela (1998) and Monica (ibid). All of these studies found higher incidences of poor pregnancy outcomes among rural teenage mothers than their urban counterparts. Negussie (ibid), and others blames this on poverty, social isolation, shortage of medical services, and other basic services in rural areas. Information regarding residence/ location and pregnancy outcomes in Uganda is still scanty.

2.1.2.5 Occupation

Occupation is associated with pregnancy outcome due to its contribution to income and thus the ability to afford maternal health services; although it is also argued that some employed mothers may fail to get time to seek maternal care especially when pregnant.

Negussie (ibid) found out that most teenage mothers in Ethiopia were largely uneducated and poorer.

Gebremariarn (ibid) also reports that the effect of the teenage household income, among other factors is strongly associated with prenatal care and attended delivery. There is a general agreement among different scholars that being poor highly influences the pregnancy outcomes of teenagers.

ORC Marco also note that young mothers who were less educated were less likely to utilize the available health services thereby leading to poor health outcomes to themselves and their children.

2.1.3 Pregnancy outcomes

2.1.3.1 Maternal morbidity

This is the health complications teenage mothers get while they are still pregnant, during and after child birth.

Murray, (1998), in his assessment of safe motherhood in Uganda identified fever, excessive headache, pale anaemia, severe vomiting and yellow vomiting as some of the ill health conditions that mothers get while pregnant. Other illnesses include malaria, HIV/AIDS/ STDs, Hypertension, Pre-eclampsia and Diabetes.

2.1.3.2 Birth weight

Birth weight is a factor associated with child survival particularly in the first year and according to UDHS, (2006), low birth weight is related to poor nutrition, anemia, malaria, smoking, experience of violence and physically demanding work during pregnancy, among others. Because of the poor conditions, most teenage mothers, leave in, they are most likely to have poor nutrition, to suffer from malaria and become aenemic.

Children whose birth weight is less than 2.5 kilograms are considered to have a higher risk of early childhood death and or morbidity. The issue of birth weight in Uganda is complicated by the fact that majority of mothers do deliver from a health facility, which means that birth weight for most of the children is not recorded.

The 2006 UDHS indicate that only one in three children, (35%) in Uganda are weighted at birth. For the records that were available, 13% of the children born to mothers below 20 years had their children's birth weight lower than 2.5 kilograms, higher than the national rate of 11%. During the study area Kampala, majorly Makindye division, majority of the teen mothers delivered outside a health facility and thus there was no reliable data to be used for further analysis.

2.1.3.3 Deaths of infants

According to the UDHS, (2006), majority of the infant deaths were highest among children born to mothers below the age of 20 years (neonatal-47%, postnatal 57%, infant mortality 103% and child mortality 77%).

The data indicates that children born to mothers 15 to 19 had a 57% higher risk of dying before one month than those born to mothers 20 to 29 years of age. Likewise, children born to mothers aged 15 to 19 had a 27% higher risk of dying before one year than those born to mothers 20 to 29 years of age. The survey further indicates that even child born after the age of 40 years was associated with a 19% increase in the child's risk of death before one year compared with the risk of children born to mothers aged 20 to 29 years of age.

2.2 Response of Health Care Services

Available statistics indicate that at present there are 1393 health units in Uganda, including 96

Hospitals, 197 health centres, 133 dispensaries/ maternity units, 11 maternity units. Over 50% of hospitals are in urban areas where only 11 % of the population lives and most health centres are near trading centres.

The geographic distribution of health personnel does not reflect needs. According to the Health facility inventory of 1992, 76% of doctors, 80% of midwives, 70% of nurses and 64% of medical assistants are working in urban areas. Overall, there are 27,000 people for every doctor staff.

The health sector as a whole is very dependent on donor contributions both for capital investment as well as operational cost.

While we have for decades decried poverty, gender discrimination, and a host of other issues for driving women dis-empowerment, in Uganda, alarming rates of teenage pregnancies are becoming a major cause for worry to the women rights movement and a possible threat to national development. Pregnancy rates amongst teenage girls are quoted at 25% (Uganda Population Secretariat, 2011), making Uganda one of the countries with the highest rates of teenage pregnancies in Sub-Saharan Africa. One would think that at this age, any child should be acquiring an education which would brighten their fixture prospects; unfortunately, for many young women this is not the case.

The costs related to teenage pregnancies are immense. Teenage mothers are often not able to complete secondary school which makes it difficult for them to find decent jobs to take care of themselves and their children.

Consequently many children of teenage mothers are unable to get an education and they too are likely to fall into poverty creating a vicious cycle of early pregnancies, illiteracy and poverty which can be hard to DreaK. Ivior higher in teenage mothers compared to older women; (World Health Organization) this does not only pose a challenge in responding to maternal and infant mortality but can be financially straining to families in terms of providing health care to the teenage mother particularly when complications arise during pregnancy or during child delivery.

Sexual abuse of children is on the rise in Uganda, ANPPCAN (African Network for the Prevention and Protection against Child Abuse and Neglect) reports that "at least 628 children are defiled per month countrywide and that even though the Penal Code Act was amended to give tougher sentences to defilers, this is not being implemented". This state of affairs is partly to blame for the skyrocketing teenage pregnancies (Uganda Bureau of Statistics, UDHS 2011). However, it would be unfortunate for us to assume that all sexual interactions by teenagers are coerced, sometimes teenagers have consensual sex- often times this is clandestine in nature out of fear of rebuke from parents and community leaders. Often, this kind of sex is not protected due to the presumed risks involved in purchasing, carrying a condom or other forms of contraceptives.

This highlights a big problem; how accessible are contraceptives for young people? Various myths surrounding the usage of contraceptives still exist and these have left many people ignorant about contraceptives, how they should be used and their possible side effects. It is no news that one of the reasons why the country's population growth rates are escalating is because of low use of contraceptives.

Contraceptives' use stands at 24% and the unmet need for contraceptives stands at 34% according to the 2011 Uganda Demographic and Health Survey. Youth Friendly Services are still very limited; only 7% of health facilities in Uganda provide Youth Friendly Services (Ministry Of Health, 2007).

Young people tell of how a health care provider looked at them disapprovingly when they asked about condoms or how they were discouraged to use any form of contraception reasoning that it would reduce their chances of having children.

Whereas the "ideal" remains that young people should abstain until they are married, it is our duty to provide them with accurate and comprehensive sexuality education so that they can make informed sexuality related decisions. Undoubtedly, ensuring that young people can access youth friendly health related services creates a platform for free expression and exchange of ideas and late

2.3 The prevention strategies for teenage pregnancies

A Kentucky Teen Pregnancy Prevention Team (KTPPT) was established and met in January, 2010. This team of 27 members includes public health educators from different areas of the state, DPH/DWH staff, MCH staff, Substance Abuse staff from the Department for Behavioral Health, physicians in Adolescent GYN and Pediatrics, community-based organizations that address teen pregnancy; Coordinated School Health (CSH) staff; FRYSC staff, a member of the Governor"s Commission on Women, school nurses, and a teen mother.

The team strategized the problem of teen pregnancy using information gathered from the MCH public forums, the sexuality education survey and the teen impact group. The team created a mission and developed four goals to address the issue of teen pregnancy in Kentucky.

The DWH held a Teen Pregnancy Prevention Summit on May 10, 2010.

Attendees were public health educators and directors, school educators, FRYSC staff, staff from community-based organizations and other interested parties. The 175 participants represented 68 of the 120 counties in Kentucky.

Participants chose a goal specific workgroup in the afternoon. Each workgroup developed specific objectives that addressed one of the four goals set forth by the KTPPT in January. Developed objectives were shared with all participants and plans were made to publish this Teen Pregnancy Prevention Strategic Plan defining these established goals and objectives. President Obama signed into law the Patient Protection and Affordable Care Act (commonly called the Health Reform Bill) on March 23, 2010.

The Act amended Title V of the Social Security Act to include a new formula grant program entitled the Personal Responsibility Education Program (PREP) and reinstated the Title V State Abstinence Education Grant. In Kentucky, these funds will be administered by the Department for Public Health, Division of Women's Health to provide age appropriate personal responsibility curriculum to youth in 5th- 12^{th} grade and to provide parent and community education in over 77 participating counties.

Additional teen pregnancy prevention efforts are taking place at the state and local level. The Kentucky Teen Pregnancy Coalition (KTPC), a state-wide organization, participates in multiple activities in teen pregnancy prevention. KTPC provides a fall and spring conference to provide education and information to educators, health care providers and other interested persons. This organization provides resources and information on their website: http://www.kytpc.org/ and advocates on a local and state level for teen pregnancy prevention efforts.

The University Of Louisville Kent School Of Social Work has received Federal Teen Pregnancy Prevention: Tier 2 grant funds to implement the Creating Healthy Adolescents through Meaningful Prevention Services Program (CHAMPS) in the Jefferson County area. Local coalitions designed to promote positive youth development exist in locations throughout the state. Prevention of teenage pregnancies will improve the well-being of our teenagers, families, communities and children. Teenage pregnancy prevention will also decrease the social and economic burden so that educational, health and social resources can benefit a larger population.

This strategic plan was developed through the collaborative efforts of the Kentucky Teen Pregnancy Prevention Team and the attendees of the 2010 Teen Pregnancy Prevention Summit. Reference will be made to the work of these strategic planning partners throughout this publication.

A toolkit for teen pregnancy prevention has been developed by the Division of Women"s Health to complement the strategic plan.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter dealt with the research design, population of study, sample size, sampling procedure, data sources, data collection instruments, validity and reliability of the instruments , research procedure, data analysis and ethical considerations in the study.

3.1 Research Design

This study used both quantitative and qualitative research approaches. The quantitative research approach consisted of a cross-sectional research design. Cross-sectional design was used because it allows for the study of the population at one specific time and the difference between the individual groups within the population to be compared. The case study design as a qualitative research design was also used. The choice of these approaches and the designs was dependent on the nature of the study variables.

3.2 Study Population

The target population of this study were the community members who reside in Makindye division, Kampala. According to the report from the MP Makindye East, (2015), Makindye divison consists of 516,210 members. The study concentrated on 100 women from Makindye East. The researcher chose Makindye division because it had the required number of staff who had the required information to the researcher and due to proximity to the researcher's place of residence.

3.3 Sample size

The sample size for this study were 80 respondents who were selected from the target population of 100 women from Makindye division. This sample was arrived at using Sloven's formula of sample size computation which states that;

$n=N/1+N\ (e^2)$

Where, n is the sample size, N is the target population, e is the error, which is 0.05

$N=100/1+100(0.05)^2$

$n=80$

3.4 Sampling Procedures

To select the sample of 80 respondents out of 100 target population, Purposive sampling technique was used. In this technique these respondents were selected depending on the purpose or interest of the researcher. The researcher used an inclusion or exclusion criteria in that the respondents to be considered should only be the ones willing to participate in the study.

3.5 Data Sources

The source of data for this study was majorly primary sources. The primary data of this study was sourced by questionnaires.

3.6 Data Collection instruments

The data collection instruments were basically questionnaires. Questionnaires by definition mean a set of printed questions addressed by the researcher to the respondent for him or her to answer and after answering return the questionnaires to the researcher. The questionnaires were administered personally by the researcher to the respondents and collected after time interval. The questionnaires comprised of both closed ended and open ended questions that required the respondents to answer all the questions to the best of their knowledge. The questionnaires were used because they are cheap, quicker, they cover many respondents, and they are free from interview bias and give accurate information since respondents take their time to answer the questions. However, they had a disadvantage of non-despondence.

3.7 Validity and Reliability of the instruments

3.7.1 Validity

The study tested three types of validity, face validity, content validity.

Face validity was achieved with the guidance of experts in the field of social sciences. The researcher worked hand in hand with her research supervisor to adjust the instruments accordingly.

It measured the content validity of the instruments. In order to test this content validity of the instruments, the researcher availed the questionnaire to two experts to check each item for language clarity, relevance, and comprehensiveness of the content. The items were rated as follows:

4 – Very relevant

3 – Quite relevant

2 – Somewhat relevant

1 – Not relevant

The researcher then put the items in 2 groups, with categories 1 and 2 in one group and the other 3 and 4 in the other group. The researcher then calculated the Content Validity Index (CVI) using the formula below:

$$CVI = \frac{\text{Items rated as very relevant and relevant (3 and 4)}}{\text{Total number of items}}$$

For the instrument to be valid, the CVI should be within the accepted statistical range of 0.5 to 1, specifically, the instrument which had the necessary content validity, it had a CVI of 0.7 and above.

3.7.2 Reliability of the instruments

Reliability is a measure of the degree to which research instruments yield consistent results or data after repeated trials.

The test-retest technique was used to assess the reliability (accuracy) of the instruments. The researcher devised the instruments to 5 qualified respondents from Makindye division, Kampala. These respondents were not included in the actual study. In this test- retest technique, the research instruments were administered twice to the same subjects after the appropriate group of the subject is selected, then the initial conditions were kept constant, the scores were then correlated from both testing periods to get the coefficient of reliability or stability. The tests and the trait measured if they were stable, indicated consistent and essentially the same results in both times (Treece and Treece, 1973).

This was done in the following ways: the appropriate group of subject was selected (05 qualified respondents); then the test was administered to the subject; all initial conditions was kept constant; a time lag of one week was waited and then the same test was administered to the same subject; the scores were correlated from both testing periods. If the scores were the same or nearly the same, the conclusion was the instrument is valid.

Also, internal consistency of the items will be measured using Cronbach's alpha coefficient. The items of the questionnaire will be considered to represent a measure of high internal consistency if the total alpha value is more than 0.7.

3.8 Data Collection Procedures

Before Administration of Questionnaires

- An introduction letter was obtained from the College of Humanities and Social sciences of Kampala International University after the approval of the validity of the research instruments.

During Administration of Questionnaires

- The researcher briefed the respondents about his intentions to carry out a study at their district headquarters.
- The researcher then asked the respondents to sign the informed consent form.
- The researcher asked the respondent to answer all the questions in the questionnaires.

After Administration of Questionnaires

- The researcher retrieved the questionnaires after five days and check for the completeness of all answers. The researcher then arranged for data analysis.

3.9 Data Analysis

Data from the field was compiled, sorted, edited and coded to have the required quality, accuracy and completeness. The researcher use Statistical Package for Social Sciences software (SPSS Version 22.0) to help in the analysis of the data gathered. Frequencies and percentages was used to analyze the demographic data of the respondents. Descriptive statistics tools (frequency and frequency counts) were used to analyse the objectives.

3.10 Ethical Considerations

Authorization

This will involve getting consent of the respondents.

Anonymity and Confidentiality

The names or identifications of the respondents will be anonymous and information collected from them will be treated with utmost confidentiality.

Integrity

The researcher will act honestly, fairly and respectfully to all other stakeholders that will be involved in this study.

Ascriptions of authorships

The researcher will accurately attribute to the sources of information in an effort to celebrate the works of past scholars or researchers. This will ensure that no plagiarism occurs.

Scientific adjudication

The researcher will work according to generally acceptable norms of research.

CHAPTER FOUR
PRESENTATION, ANALYSIS AND INTERPRETATION OF THE FINDINGS

4.0 Introduction

This chapter presents empirical findings and references to the research questions in chapter one. The findings were obtained from both primary and secondary sources. They presented and analyzed using frequency tables, percentages (frequency counts).

4.1 Demographic characteristics of the respondents

4.1.1 Age of respondents

It was necessary to find out the distribution of respondents in Makindye division, Kampala by age. The findings were as shown on table 1 below.

Table 1: Showing age of respondents

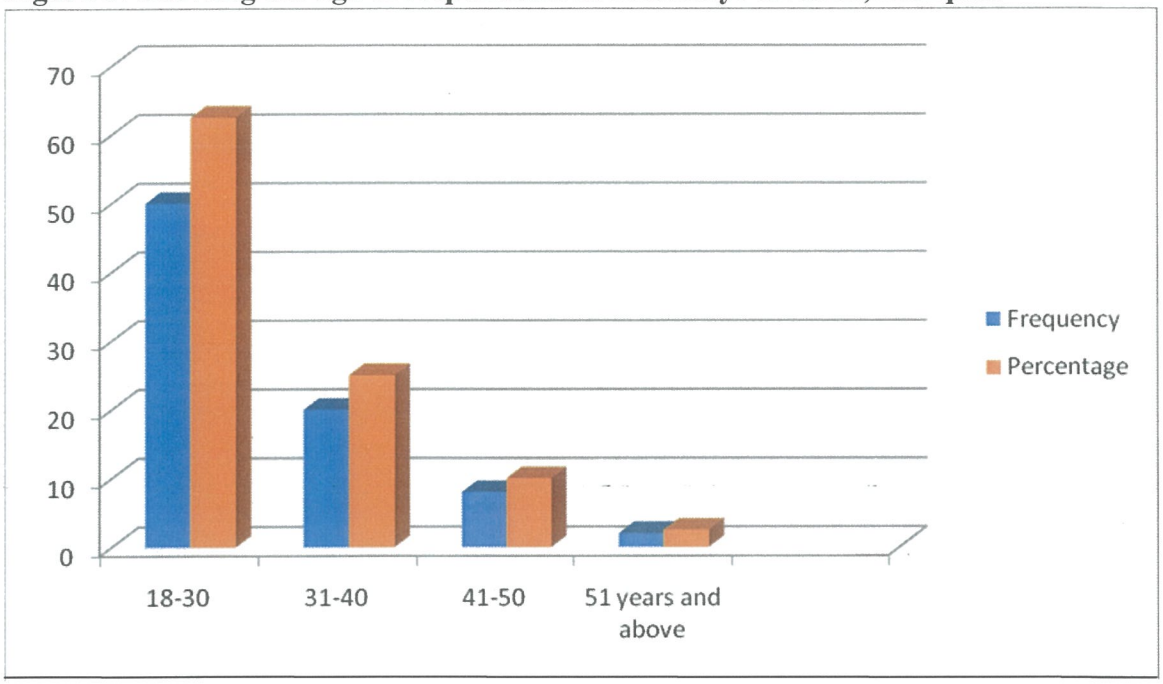
Age of respondents	Frequency	Percentage (%)
18-30	50	62.5
31-40	20	25.0
41-50	08	10.0
51 years and above	02	2.5
Total	80	100

Source: Primary data , (2016)

Table 1 above showed that 50 out of 80 respondents represented by 62.5% were between 18-30 years of age, 20 (25.0%) were 31-40, 08(10.0%) were 41-50 while only 2(6.6%) were of age group 51 years and above. This implies that most of the women in Makindye division, Kampala fall under the age of 18-30.

These results were further represented on figure1 below.

Figure 1: Showing the age of respondents in Makindye division, Kampala



Source: Primary data, (2016)

4.1.2 Education level of respondents

It was necessary to determine the distribution of respondents in Makindye division, Kampala by level of education. The respondents were asked about their level of education and the results were tabulated in a table 2 below.

Table 2: Showing Education level of respondents in Makindye division, Kampala

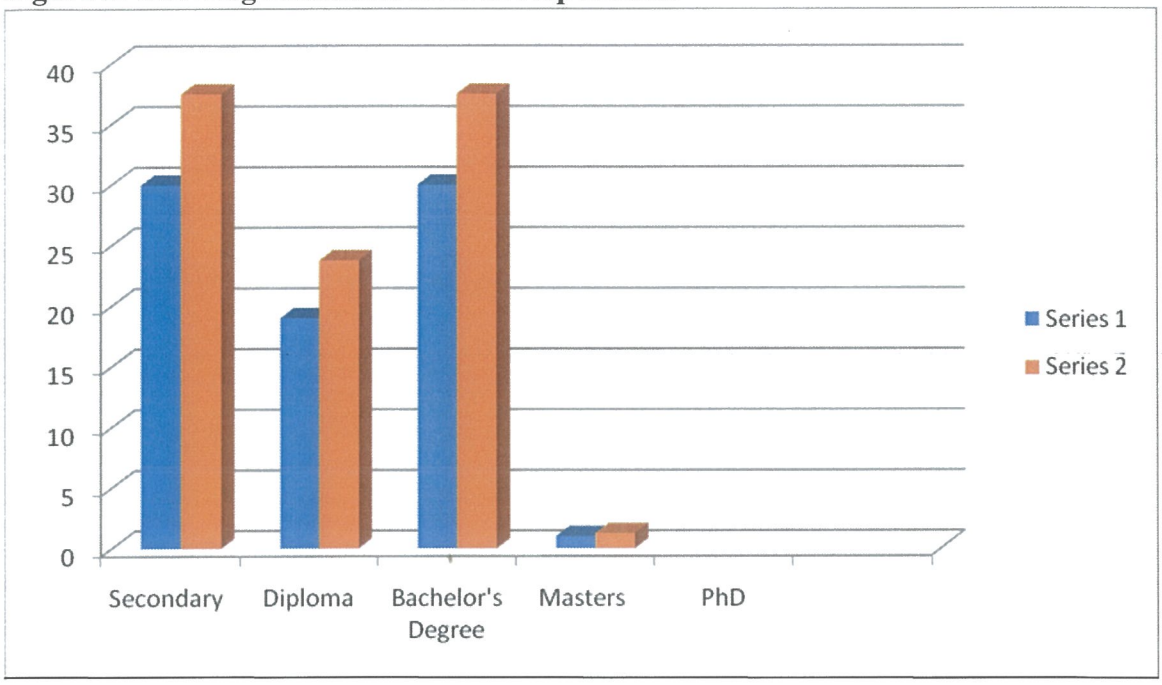
Education level of respondents	Frequency	Percentage (%)
Secondary	30	37.5
Diploma	19	23.75
Bachelors' degree	30	37.5
Masters	01	1.25
PhD	-	-
Total	80	100

Source: Primary data, (2016)

In the table above, 30 respondents out of 80 represented by 37.5% had completed Secondary level of education, also 30(37.5%) are Bachelor's degree holders, 19(23.75%) are Diploma

holders , only 01(1.25%) is a Master's Degree holder, there was no one who was a PhD holder. These results were further represented in the figure2 below.

Figure 2: Showing Education level of respondents



Source: primary data, (2016)

4.1.3 Marital status of respondents

It was necessary to find out the distribution of respondents in Makindye division, Kampala by marital status. The findings on the respondents' distribution in Makindye division, Kampala by marital status was as shown on table 3 below.

Table 3: Showing the marital status of respondents in Makindye division, Kampala.

Marital status of respondents	Frequency	Percentage (%)
Married	18	22.5
Widowed	15	18.75
Divorced	25	31.25
Single	22	27.5
Total	**80**	**100**

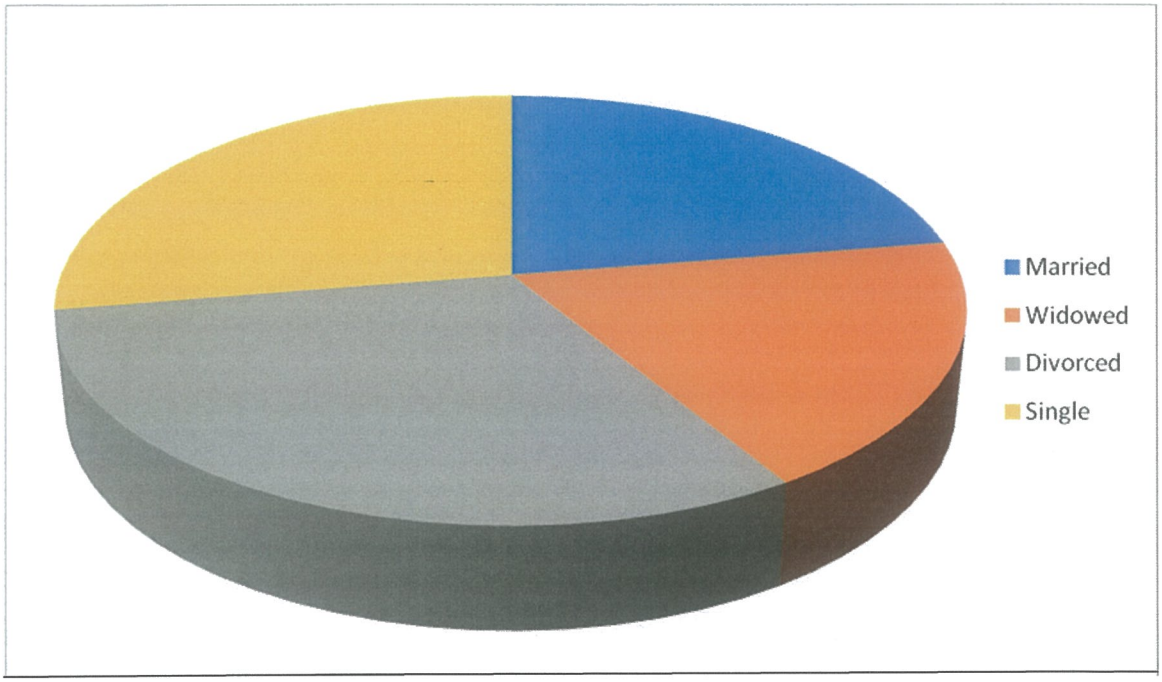
Source: Primary data, (2016)

In the table above, 18 respondents out of 80 represented by 22.5% of the total respondents were married, 15(18.75%) widowed, 25(31.25%) had divorced while 22(27.5%) of the total

respondents were single. This implies that most of the women in Makindye division, Kampala divorced followed by those ones who are single.

The results were also presented on figure3 as shown below.

Figure 3: Showing the marital status of respondents



Source: primary data, (2016)

4.1.4 Occupation of respondents in Makindye division, Kampala

It was necessary to find out the distribution of respondents in Makindye division, Kampala by the occupation. The respondents were therefore, asked about their Occupation and the results were shown in table4 below.

Table 4: showing Occupation of respondents in Makindye division, Kampala

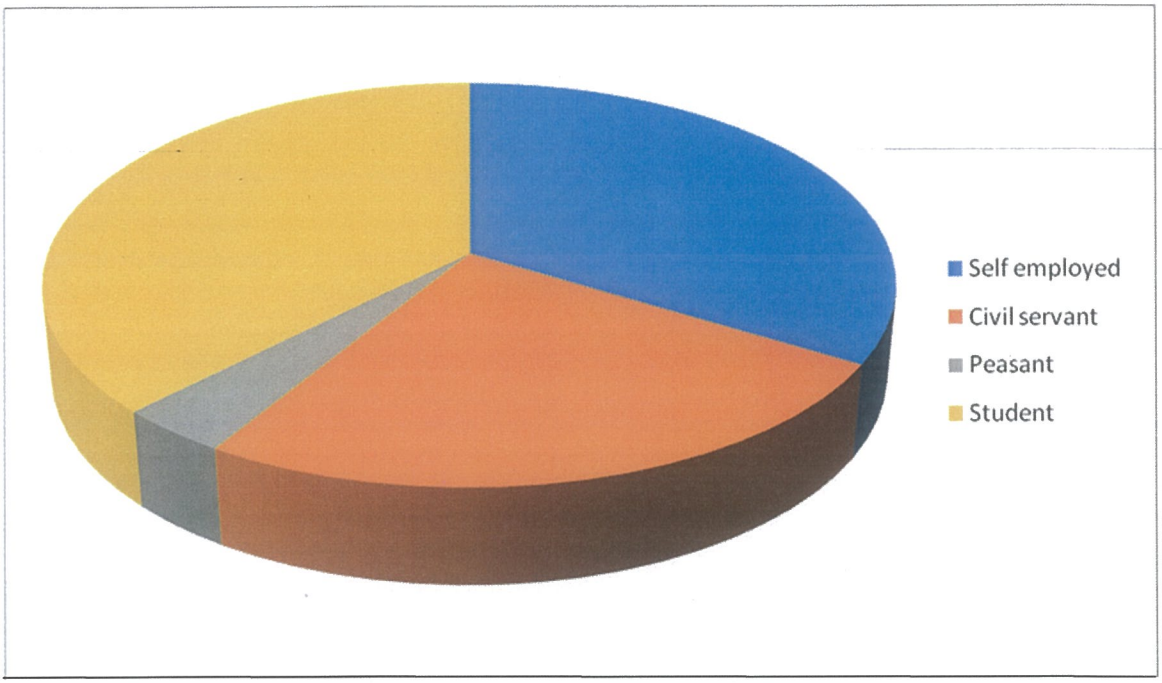
Occupation of respondents	Frequency	Percentage
Self Employed	27	33.75
Civil Servant	20	25.00
Peasant	3	3.75
Student	30	37.5
Total	80	100

Source: Primary data, (2016)

In the table 4 above, 27 respondents out of 80 respondents represented by 33.75% were self-employed, 20(25.00%) were civil servants, 3(3.75%) were peasants while all 30(37.5%) were students. This implies that most of women in Makindye division are students who were in both Secondary level and institutions of higher learning.

The above findings can also be presented on a figure as shown on figure 4 below.

Figure 4: showing Occupation of respondents



Source: primary data, (2016)

4.2 The extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala.

A question was derived from the first objective of the research study about what is the extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala? To achieve this objective, respondents were subjected to a number of questions to provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was given in respect to the extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala.

4.2.1 The extent of teenage pregnancies in Makindye division, Kampala

It was necessary to find out the extent of teenage pregnancies in Makindye division, Kampala. The findings was as shown on table 5 below.

Table 5: showing the extent of teenage pregnancies in Makindye division, Kampala

The extent of teenage pregnancies	Frequency	Percentage
Too much teenage pregnancies	37	46.25
Moderate teenage pregnancies	30	37.5
Reduced number of teenage pregnancies	13	16.25
Total	80	100

Source: Primary data, (2016)

According to the research findings in the table 5 above, 37 respondents out of 80 total respondents represented by 46.25% of the total respondents responded that there is too much teenage pregnancies in Makindye division, Kampala; 30(37.5%) of the total respondents responded that there is moderate teenage pregnancies in Makindye division, Kampala; and only 13(16.25%) of the total respondents in Makindye division, Kampala replied that the teenage pregnancies in Makindye division, Kampala is on a reduced number . This implies that there is increased number of teenage pregnancies among women in Makindye division, Kampala.

4.2.2 The causes of teenage pregnancies in Makindye division, Kampala

It was necessary to identify the causes of teenage pregnancies in Makindye division, Kampala.

To identify the causes of teenage pregnancies, the respondents were asked questions about the causes of teenage pregnancies and the results were tabulated in the table5 below.

Table 5: Showing the causes of teenage pregnancies among women in Makindye division, Kampala

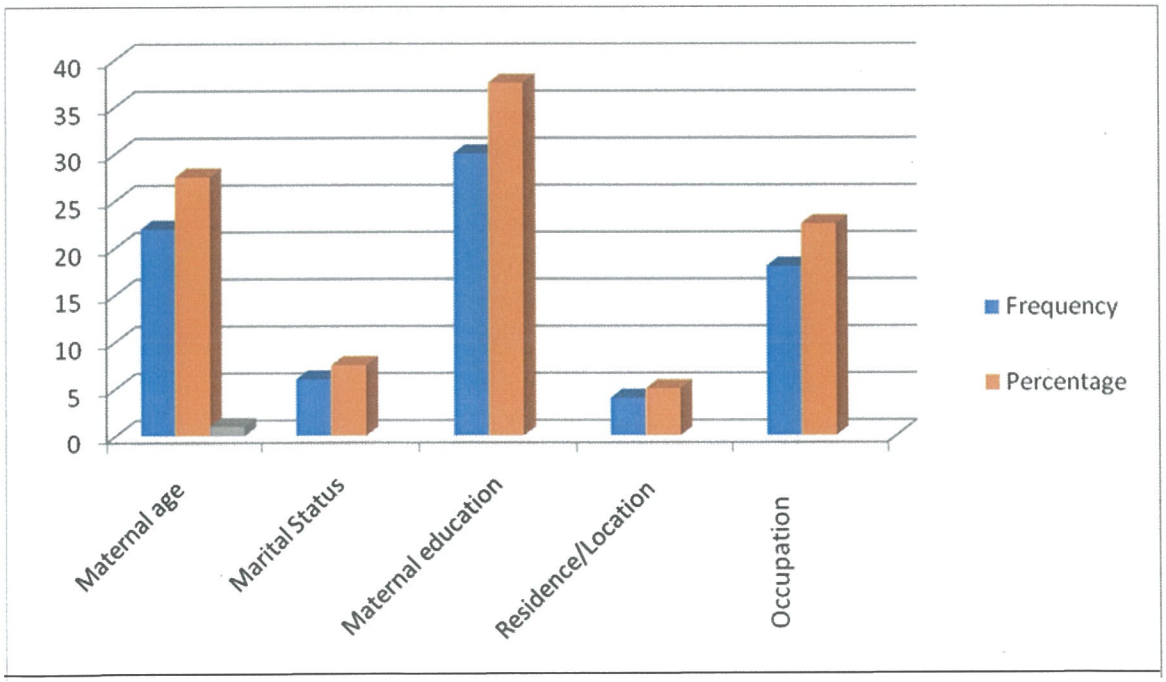
The causes of teenage pregnancies	**Frequency**	**Percentage (%)**
Maternal age	22	27.5
Marital status	06	7.5
Maternal education	30	37.5
Residence/Location	04	5.0
Occupation	18	22.5
Total	**80**	**100**

Source: primary data, (2016)

According to the research findings In table5 above, 22 respondents out of 80 total respondents represented by 27.5 % of the total respondents said that maternal age was one of the causes of teenage pregnancies in Makindye division, Kampala; 06 (7.5%) of the respondents responded that marital status is one of the causes of teenage pregnancies, 30(37.5%) replied that maternal education is another cause of teenage pregnancies; 04(5.0%) responded that residence/location of women is another cause of teenage pregnancies while 18(22.5%) of the total respondents replied that the occupation of women is a cause of teenage pregnancies in Makindye division, Kampala. This implies that maternal education is a major cause of teenage pregnancies in Makindye division, followed by the maternal age of women, also followed by the occupation of women.

These results were also presented on the figure as shown on figure5 below.

Figure 5: Showing the causes of teenage pregnancies among in Makindye division, Kampala.



Source: primary data, (2016)

4.2.3 The pregnancy outcomes in Makindye division, Kampala

It was necessary to identify teenage pregnancy outcomes in Makindye division, Kampala.

To identify teenage pregnancy outcomes, the respondents were asked questions about these teenage pregnancy outcomes and the results were as shown on table 6 below.

Table 6: Showing teenage pregnancy outcomes in Makindye division, Kampala

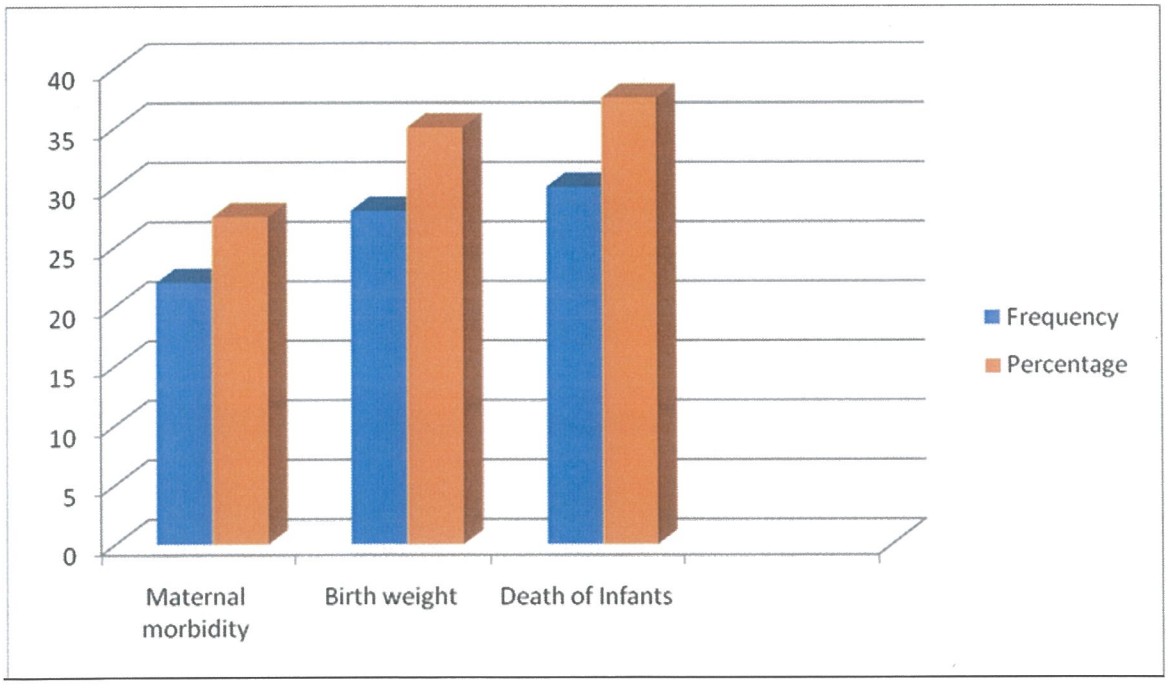
Teenage pregnancy outcomes	**Frequency**	**Percentage (%)**
Maternal morbidity	22	27.5
Birth weight	28	35.0
Death of Infants	30	37.5
Total	**80**	**100**

Source: primary data, (2016)

According to the research findings In table 6 above, 22 respondents out of 80 total respondents represented by 27.5 % of the total respondents responded that maternal morbidity was one of the outcomes of teenage pregnancies in Makindye division, Kampala; 28 (35.0%) of the total respondents responded that birth weight is one of the outcomes of teenage pregnancies whereas 30(37.5%) replied that death of infants is another outcome of teenage pregnancies in Makindye division, Kampala. This implies that death of infants is a major outcome of teenage pregnancies in Makindye division, followed by loss of weights during children's birth, and lastly the maternal morbidity.

These results were also presented on the figure as shown on figure 6 below.

Figure 6: Showing teenage pregnancies outcomes in Makindye division, Kampala.



Source: primary data, (2016)

4.3 The level of teenage response to comprehensive health care services in Makindye division, Kampala

A question was derived from the second objective of the research study about what is the level of teenage response to comprehensive health care services in Makindye division, Kampala? To achieve this objective, respondents were subjected to a number of questions to provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was as shown on table 7 below.

Table7: **The level of teenage response to comprehensive health care services in Makindye division, Kampala.**

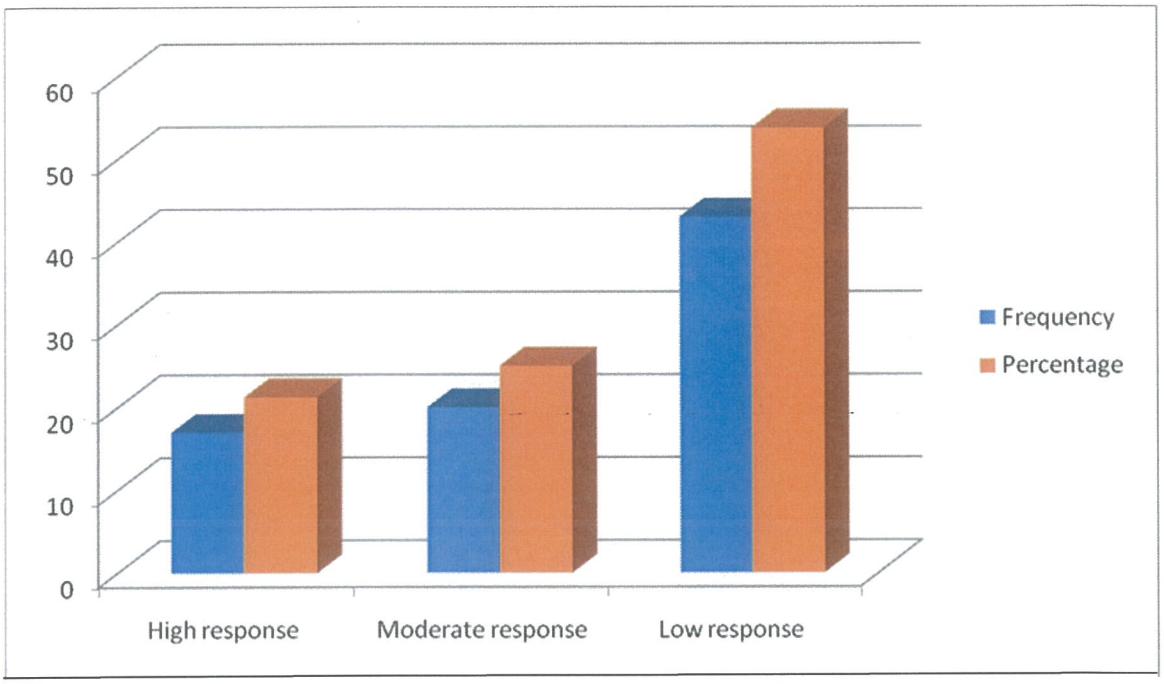
The level of teenage response to comprehensive health care services	Frequency	Percentage
High response	17	21.25
Moderate response	20	25.0
Low response	43	53.75
Total	80	100

Source: Primary data, (2016)

According to the research findings in the table 7 above, 17 respondents out of 80 total respondents represented by 21.25% of the total respondents responded that there is high teenage response to comprehensive health care services in Makindye division, Kampala; 20(25.0%) of the total respondents responded that there is moderate teenage response to comprehensive health care services in Makindye division, Kampala; and all 43(53.75%) of the total respondents in Makindye division, Kampala replied that the teenage response to comprehensive health care services in Makindye division, Kampala is low . This implies that increased number of teenagers in Makindye division, Kampala donot respond to comprehensive health care services.

The above information can also be presented on a figure as shown on figure 7 below.

Figure 7: Showing the level of teenage response to comprehensive health care services in Makindye division, Kampala



Source: primary data

4.4 Teenage pregnancy prevention measures in Makindye division, Kampala

A question was derived from the third objective of the research study about what are the teenage pregnancy prevention measures in Makindye division, Kampala? To achieve this objective, respondents were subjected to a number of questions to provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was as shown on table 8below.

Table 8: Showing teenage pregnancy prevention measures in Makindye division, Kampala

Teenage pregnancy prevention measures	Frequency	Percentage (%)
Encouraging and emphasizing maternal education	26	32.5
Encouraging women to get pregnancy at late maternal age	08	10.0
Encouraging women to engage in various activities as their occupations	22	27.5
Coming up with teenage pregnancy prevention team	14	17.5
Establishing a teen pregnancy coalition-which is a state wide organization which participates in multiple activities in teen pregnancy prevention	10	12.5
Total	80	100

Source: primary data, (2016).

According to the research findings from table 8 above, all 26 respondents out of 80 total respondents represented by 32.5 % of the total sample population responded that encouraging and emphasizing maternal education is a prevention measure to teenage pregnancies, 08(10.0%) of the total sample population responded that encouraging women to get pregnant at mature maternal age is a prevention measure to teenage pregnancies, 22(27.5%) responded that encouraging women to engage in various activities as their occupations a prevention measure to teenage pregnancies , 14(17.5%) of the total sample population responded that coming up with teenage pregnancy prevention team is a prevention measure to teenage pregnancies and 10(12.5%) of the total sample population responded that establishing a teen pregnancy coalition-which is a state wide organization which participates in multiple activities in teen pregnancy prevention is a prevention measure to teenage pregnancies in Makindye division Kampala. This implies that encouraging and emphasizing maternal education is a major prevention measure to teenage pregnancies followed by encouraging women to engage in various activities as their occupations.

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the findings, conclusions, recommendations and suggested areas that need further research following the study objectives and study hypothesis.

5.1Discussion of findings

5.1.1 Findings on demographic data collected in Makindye division, Kampala

Study findings according to table1 above showed that 50 out of 80 respondents represented by 62.5% were between 18-30 years of age, 20 (25.0%) were 31-40, 08(10.0%) were 41-50 while only 2(6.6%) were of age group 51 years and above, implying that most of the women in Makindye division, Kampala fall under the age of 18-30.

According to study findings on table 2 indicate that, 30 respondents out of 80 represented by 37.5% had completed Secondary level of education, also 30(37.5%) are Bachelor's degree holders, 19(23.75%) are Diploma holders , only 01(1.25%) is a Master's Degree holder, there was no one who was a PhD holder.

According to study findings on table 3 indicate that, 18 respondents out of 80 represented by 22.5% of the total respondents were married, 15(18.75%) widowed, 25(31.25%) had divorced while 22(27.5%) of the total respondents were single. This implies that most of the women in Makindye division, Kampala divorced followed by those ones who are single.

Also study findings on table 4 showed that, 27 respondents out of 80 respondents represented by 33.75% were self-employed, 20(25.00%) were civil servants, 3(3.75%) were peasants while all 30(37.5%) were students. This implies that most of women in Makindye division are students who were in both Secondary level and institutions of higher learning.

5.1.2 The extent of teenage pregnancies, causes and pregnancy outcomes in Makindye division, Kampala.

To achieve this objective, respondents were subjected to a number of questions to provide answers to the research question derived from this objective. The questions administered to the respondents were aimed at investigating the respondent's response towards the stated research objective. Data analysis and interpretation revealed the following findings on this objective. Based on the analysis of chapter four, from Table 5: the findings showed that, 37

respondents out of 80 total respondents represented by 46.25% of the total respondents responded that there is too much teenage pregnancies in Makindye division, Kampala; 30(37.5%) of the total respondents responded that there is moderate teenage pregnancies in Makindye division, Kampala; and only 13(16.25%) of the total respondents in Makindye division, Kampala replied that the teenage pregnancies in Makindye division, Kampala is on a reduced number . This implies that there is increased number of teenage pregnancies among women in Makindye division, Kampala.

5.1.3 The level of teenage response to comprehensive health care services in Makindye division, Kampala.

To achieve this objective, respondents were subjected to a number of questions to provide answers to the research question derived from this objective. The questions administered to the respondents were aimed at investigating the respondent's response towards the stated research objective. Data analysis and interpretation revealed the following findings on this objective. Based on the analysis of chapter four, from Table 6: the findings showed that, 17 respondents out of 80 total respondents represented by 21.25% of the total respondents responded that there is high teenage response to comprehensive health care services in Makindye division, Kampala; 20(25.0%) of the total respondents responded that there is moderate teenage response to comprehensive health care services in Makindye division, Kampala; and all 43(53.75%) of the total respondents in Makindye division, Kampala replied that the teenage response to comprehensive health care services in Makindye division, Kampala is low . This implies that increased number of teenagers in Makindye division, Kampala donot respond to comprehensive health care services.

5.1.4 The teenage pregnancy prevention measures in Makindye division, Kampala.

To achieve this objective, respondents were subjected to a number of questions to provide answers to the research question derived from this objective. The questions administered to the respondents were aimed at investigating the respondent's response towards the stated research objective. Data analysis and interpretation revealed the following findings on this objective. Based on the analysis of chapter four, from Table 7: the findings According to the research findings from table 8 above, all 26 respondents out of 80 total respondents represented by 32.5 % of the total sample population responded that encouraging and emphasizing maternal education is a prevention measure to teenage pregnancies, 08(10.0%) of the total sample population responded that encouraging women to get pregnant at mature maternal age is a prevention measure to teenage pregnancies, 22(27.5%) responded that

encouraging women to engage in various activities as their occupations a prevention measure to teenage pregnancies , 14(17.5%) of the total sample population responded that coming up with teenage pregnancy prevention team is a prevention measure to teenage pregnancies and 10(12.5%) of the total sample population responded that establishing a teen pregnancy coalition-which is a state wide organization which participates in multiple activities in teen pregnancy prevention is a prevention measure to teenage pregnancies in Makindye division Kampala. This implies that encouraging and emphasizing maternal education is a major prevention measure to teenage pregnancies followed by encouraging women to engage in various activities as their occupations.

5.2 Conclusions

From the findings of the study, on respondents' background information the researcher concluded that majority of respondents in this sample were in their early adulthood age, that is, 18-30 years, women in Makindye division, Kampala are moderately educated, most of the women in Makindye division, Kampala divorced and most of women in Makindye division are students who were in both Secondary level and institutions of higher learning.

It can also be concluded that there is increased number of teenage pregnancies among women in Makindye division, Kampala.

It can also be concluded that increased number of teenagers in Makindye division, Kampala do not respond to comprehensive health care services.

And that encouraging and emphasizing maternal education is a major prevention measure to teenage pregnancies followed by encouraging women to engage in various activities as their occupations.

5.3 Recommendation

The researcher recommends to the government through the state and division that it should encourage and emphasize maternal education.

The researcher recommends to the division that it should encourage women to get pregnant at a mature maternal age.

The researcher recommends to the community mostly women that they should engage in various activities as their occupations such as small scale businesses (restaurants, mobile money shops, retail shops among others) which can act as source of income.

The researcher recommends to the government to come up with teenage pregnancy prevention team in the division.

Establishing a teen pregnancy coalition-which is a state wide organization which participates in multiple activities in teen pregnancy prevention.

5.4 Limitations of the study

The research study faced the following problems:

- Most of the respondents in Makindye division, Kampala were too busy, so less time was posed to the researcher.
- Some of the community members in Makindye division, Kampala were not willing to give out information due to lack of trust between the researcher and the respondents.
- Confidentiality, in that, there is some information which was not supposed to move out of the community to the researcher, this limited the research study.
- Some respondents were hesitant to give information since it does not benefit them, thus they needed to have some funds committed to them.
- The study was only limited to the case study due to limited time and resources to cover the whole Kampala. The researcher resorted to purposive sampling and yet it had its own disadvantages.
- There were transport costs that limited the study.

5.5 Areas for further research

Prospective researchers and even students are encouraged to research on the following areas;

1. Teenage pregnancies and the health of children in Makindye division, Kampala.

REFERENCES

Alan Guttmacher Institute. *Readings on Teenage Pregnancy.* Articles from Family Planning Perspectives,1995-1999. New York, NY: Alan Guttmacher Institute, 1990.

Biesmesderfer, S.C., Maggard, H.F., & Bustos, P.D. *Teenage Pregnancy Legislation in the States: 1998.* Denver, Colorado: National Conference of State Legislatures, June 1999.

Burt, M., & Levy, F. "The Estimates of Public Costs for Teenage Childbearing: A Review of Recent Studies and Estimates of 1995 Public Costs, " in *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing.* Volume II Working Papers and Statistical Appendixes. Edited by Sandra Hofferth and Cheryl Hayes. Washington, DC: National Academy Press, 1997.

Coates, D.L., & Maxwell, J.P. *Lessons Learned from the Better Babies Project.* Notes from the Field. April 1990. Available from Community Services Department, March of Dimes Foundation, 1275 Mamaroneck Ave. White Plains, NY 10605.

Family Support Administration. *On Teen Pregnancy Prevention: A Report from the Secretary's Panel.* January 2009. U.S. Dept. of Health and Human Services. Available from SHARE Resource Center on Teen Pregnancy Prevention. P.O. Box 2309, Rockville, MD 20852. Hayes, C. ed. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing.* Volume I Final Report of the Panel on Adolescent Pregnancy and Childbearing, Committee on Child Development Research and Public Policy, National Research Council. Washington, DC: National Academy Press, 2007.

Henshaw, S.K., Kenney, A.M., Somberg, D., & Van Vort, J. *Teenage Pregnancy in the United States: The Scope of the Problem and State Responses.* New York, NY: The Alan Guttmacher Institute, 2009.

Henshaw, S.K., & Van Vort, J. "Teenage Abortion, Birth and Pregnancy Statistics: An Update" in *Family Planning Perspectives, 21*(3), March/April 2009. Included in the Alan Guttmacher Institute*Readings on Teenage Pregnancy 1990*

Kenney, A.M., & Somberg, D., *State Teenage Pregnancy Initiatives in the 1980s: An Assessment.*

Henshaw et al., 1989. op. cit. Kenney, A.M., Guardado, S., & Brown, L. "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing." *Family Planning Perspectives, 21*(2). March/ April 2009.

Koshel, J. J. *An Overview of State Policies Affecting Adolescent Pregnancy and Parenting.* Center for Policy Research, Human Resources Policy Studies. Washington, DC: National Governors' Association, 1990. Moore, K.A. "Government Policies Related to Teenage Family Formation and Functioning: An Inventory" in *Teenage Pregnancy in a Family Context: Implications for Policy.* edited by T. Ooms. Philadelphia: Temple University Press, 2001.

Moore, K.A., & Burt, M.R. *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing.* Washington, DC: Urban Institute, 2002.

Moore, K.A. *Adolescent Parents: Federal Programs and Policies.* Summer 2003. Report prepared for the C.S. Mott Foundation. Available from the author, Child Trends Inc. 2100 M St. N.W., Suite 610, Washington, DC 2003

Moore, K.A. *Facts At A Glance 2009.* Annual updated facts sheets related to teen pregnancy and childbearing in the 50 states. Available from Child Trends Inc. 2100 M St. N.W., Suite 610, Washington, DC 20037.

National Commission to Prevent Infant Mortality. *Death Before Life: The Tragedy of Infant Mortality.* A report and recommendations of the Commission. Washington, DC: National Commission to Prevent Infant Mortality, 2008.

National Commission. *Adolescent Pregnancy: An Issue Brief, 1988.* Available from the National Commission to Prevent Infant Mortality, 330 C St. S.W., Room 2006, Washington, DC 20201. National Commission. *Troubling Trends: The Health of America's Next Generation.* Report of the National Commission to Prevent Infant Mortality. February 2000. Available from the Commission, 330 C St. S.W., Room 2006, Washington, DC 20201. North Carolina Coalition (NCCAP). *The Challenge and the Choices: Teen Pregnancy in North Carolina.* Report of the Action Agenda. 2009. Available from the North Carolina Coalition of Adolescent Pregnancy, 1300 Baxter St., Suite 171, Charlotte, NC 28204.

Ooms, T. ed. *Teenage Pregnancy in a Family Context: Implications for Policy.* Philadelphia: Temple University Press, 2001 Parents Too Soon (PTS) *Progress Report.*

A program of the State of Illinois. 1988 Available from Parents Too Soon, 535 W. Jefferson, Springfield, IL 62761.

Reingold, J.R.& Associates. *Current Federal Policies and Programs for Youth. June 1987.* A report of Youth and America's Future, the William T. Grant Foundation Commission on Work, Family and Citizenship. Available from the Commission, Suite 301, 1001 Connecticut Avenue N.W., Washington, DC 20036.

Schorr, L. chair. *Better Health for Our Children: A National Strategy.* The Report of the Select Panel for the Promotion of Child Health to the U.S. Congress and the Secretary of DHHS. DHHS Pub. No. 79-55071 Washington, DC: U.S.

Government Printing Office, 2001 Select Committee on Children, Youth and Families. *Teen Pregnancy: What is Being Done? A State-by State Look.* A Committee report together with additional minority views. U.S. House of Representatives, 99th Congress. Washington, DC: U.S. Government Printing Office, 2006.

Select Committee on Children, Youth, and Families. *Federal Programs Affecting Children and Their Families, 1990.*

A report together with additional minority views. U. S. House of Representatives, 101st Congress. Washington, DC: U.S. Government Printing Office, 1990.

Southern Regional Project. *Adolescent Pregnancy in the South: Breaking the Cycle.* A Report of the Southern Regional Project on Infant Mortality. May, 1989. Available from the Southern Regional Project, 444 N.

Capitol St. N. W., Suite 240, Washington, DC 20001. Southern Regional Project. *Adolescents in the South: A Mandate for Leadership.* July 1990. Available from the Southern Regional Project, 444 North Capitol St. N. W., Suite 240, Washington, DC 20001. TEC Networks, *Theme Issue: Lessons Learned/Recommendations.* Newsletter of the Too-Early-Child-Bearing Networks of Programs Funded by the Charles Stewart Mott Foundation. No. 25, June 1990.

Weatherley, R.A., Perlman, SD. B., Levine, M.H., Klerman, L.V. "Comprehensive Programs for Pregnant Teenagers and Teenage Parents: How Successful Have They Been?" in *Family Planning Perspectives, 18*(2), March/April 1986. Included in the Alan Guttmacher Institute, Readings in Teenage Pregnancy.

APPENDICES

APPENDIX I A

TRANSMITTAL LETTER

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Dear Sir/Madam,

RE: INTRODUCTION LETTER TO CONDUCT RESEARCH IN YOUR INSTITUTION

Ms. AMUNDALA ASSUMANI is a student of Kampala International University pursuing a Bachelor's degree of Social Works and Social Administration.

She is currently conducting a field research for her dissertation entitled, Teenage pregnancies and response to comprehensive health care services in Makindye Division, Kampala.
Your division has been identified as a valuable source of information pertaining to his research project. The purpose of this letter then is to request you to avail her with the pertinent information she may need.

Any data shared with her will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to her will be highly appreciated.

Yours truly,

APPENDIX IB

TRANSMITTAL LETTER FOR THE RESPONDENTS

Dear Sir/ Madam,

Greetings!

I am a student of a Bachelor's degree of Social Works and Social Administration at Kampala International University. My study is entitled, "Teenage pregnancies and response to comprehensive health care services in Makindye Division, Kampala.". Within this context, may I request you to participate in this study by answering the questionnaire? Kindly do not leave any option unanswered. Any data you will provide shall be for academic purposes only and no information of such kind shall be disclosed to others.

May I retrieve the questionnaire within five days (5)?

Thank you very much in advance.

Yours faithfully,

Ms. AMUNDALA ASSUMANI

APPENDIX II
INFORMED CONSENT

I am giving my consent to be part of the research study of Mr. ..... that will focus on Teenage pregnancies and response to comprehensive health care services in Makindye Division, Kampala.

I shall be assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me if I ask for it.

Initials:_____

Date_____

APPENDIX III
RESEARCH INSTRUMENT

Section A: Demographic characteristics of Respondents

1. **Age**

a) ____18-30 years, b)____31-40 years, C)____41-50 years and d)___51 years and above

2. **Level of education qualification**

a) Secondary_____

b) Diploma_____

c) Bachelors Degree_____

d) Masters degree_____

e) PhD_____

3. **Marital status**

a) Single_____

b) Married_____

c) Divorced_____

4. **Occupation of the respondents**

a) Self employed _____ b) Civil servant

b) Peasant d) Students

SECTION B : THE CAUSES OF TEENAGE PREGNANCIES IN MAKINDYE DIVISION

4. What are the causes of teenage pregnancies in Makindye division?

(i).....

(ii).....

(ii).....

SECTION C: THE OUTCOMES OF TEENAGE PREGNANCIES IN MAKINDYE DIVISION

5. What are the outcomes of teenage pregnancies in Makindye division?

(i).....

(ii).....

(iii).....

SECTION D: THE TEENAGE RESPONSE TO COMPREHENSIVE HEALTH CARE SERVICES IN MAKINDYE DIVISION

6. Do the teenage mothers have positive response to comprehensive health care services in Makindye division?

Yes No

SECTION E: THE PREVENTION MEASURESTOWARDS TEENAGE PREGNANCIES IN MAKINDYE DIVISION

7. What are the measures towards prevention of teenage pregnancies in Makindye division, Kampala?

(i).....

(ii).....

(ii).....

THANKS FOR PARTICIPATING

APPENDIX IV
TIME FRAME

This table shows the time this research will be completed the study

Activities	**First month**	**Second month**	**Third month**	**Fourth month**
Proposal	**April**			
Visiting the data sources including libraries, institutions and others		**May-June**		
Final analysis			**July-August**	
Dissertation Typing, printing and submission				**September**

APPENDIX V
PROPOSED BUDGET

Particular	Quantity	Amount(in UG shs)
Stationary	Paper 2 Reams	30,000
	Printing and binding spiral 05	25,000
	Printing and hard cover binding	80,000
Transport costs		100,000
Data Analysis		20,000
Miscellaneous		75,000
	Total	**330,000**