KIBOGORA POLYTECHNIC

FACULTY OF HEALTH SCIENCE

DEPARTMENT OF NURSING

TOPIC: ASSESSMENT OF FACTORS ASSOCIATED WITH TEENAGE PREGNANCY

Case study: group scolaire Rwamagana

Period: from July 2021 to March 2022

A Research Paper was submitted in partial fulfillment of the requirements for the Bachelor's degree with honor in Bachelor Program Health Sciences

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DECLARATION

Declaration by the candidates

We, Rwabukwerere Alice and Mukamparirwa Jeannette hereby declare that this is our original work and not a duplication of any similar academic work. It has therefore not been submitted to any other institution of higher learning. All materials cited in this paper which are not our own have been duly acknowledged.

Signed……..

Date…….

Declaration by the Supervisor

I declare that this work has been submitted for examination with my approval as Kibogora Polytechnic supervisor

SUPERVISOR'SNAME…….
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DATE……..

ABSTRACT

Background: Teenage pregnancy has long been a worldwide social and educational concern for developed, developing, and underdeveloped countries (Yussif, *et al.,* 2017). Many countries continue to experience a high incidence of teenage pregnancies even if they have some intervention strategies for underrating the issue (Walag, *et al.,* 2018). Teenage pregnancies are a global social and health challenge (Gayatri, 2021). Worldwide, 38% of pregnancies belong to this group of teenage (Glynn, *et a*l., 2018) Also, each year, worldwide precise one out of five girls are mostly like to give birth at the age of 19 (DHS, 2017). These pregnancies also expose them to illegal and early marriage as well as having household responsibilities while they were still young and single parenthood. Another foremost impact might be repeating school grades and high school dropout (Yasmin, Kumar and Parihar, 2014b)**.**

Aim: The purpose of this study was to identify the factors associated with teenage pregnancy among secondary school students at Groupe Scolaire Rwamagana (G.S)

The research methodology: the study was a descriptive cross-sectional study that used a simple random sampling method during data collection among young teenage in secondary at G.S Rwamagana.

Results: Both economic factors and social factors were found as precursors to early teenage pregnancy**.** And out of 180 young teenagers, 113(62.3%) have engaged in sexual intercourse whereas 80(44.44%) do not get adequate support from their parents. And unfortunately, 32(17.2%) do not get any access to sexual and reproductive health information

DEDICATION

we dedicate this work to our father almight God,

we also dedicate it to our classmates and our helping supervisor,

our lastly deeply dedication goes to our beloved families.

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ACRONYMS

CCCN	Centre and Control Computational Neuroscience
CDC	Centre for Disease Control and Prevention
CEDAR	Convention to Eliminate All Forms of Discrimination against Women
CLAUDIO	Collectif des Ligues et Associations de Défense des Droits de l'Homme au Rwanda.
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
G. S	Group Scolaire
GDHS	Ghana Demographic and Health Survey
HD	Human Development Index
HINARI	Health Internetwork Access to Research Initiative
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
MICS	Multiple Indicator Cluster Survey
MIGEPROF	Minister of Gender and Family Promotion
MoH	Minister of Health
SPSS	Statistical Package for Social Sciences
STDs	Sexual Transmitted Diseases
TB	Tuberculosis
UND	University of Notre Dame x
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
KP	KIBOGORA Polytechnic
UK	United Kingdom
UNICEF	United Nations Children's Fund
USA	United State of America
USAID	United States Agency for international development
WPP	World Population Prospects
WHO	World Health Organizations

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CHAPTER ONE: GENERAL INTRODUCTION

1.0 INTRODUCTION

This chapter covers the background of the research study, statement of the problem, the purpose of the study, research questions, objectives of the study, significance of the study, limitations of the study, and as well as scope of the study.

1.1 BACKGROUND OF THE STUDY

The World Health Organisation(WHO) and the United States Agency for international development(USAID) define teenage as those between the ages of 10 and 19 years of age (Norton and Chandra-mouli, 2017). Teenage pregnancies are a global social and health challenge (Pérez, *et al.*, 2021). Worldwide, 38% of pregnancies belong in this group of teenage (Glynn, *et al.*, 2018). Also, each year, the worldwide precise one out of five i.e., 1/5 of girls are mostly like to give birth at the age of 19 (Gayatri, 2021). Moreover, the study conducted by Shahida and Nicholas (2014) had shown that, among the 260 million girls aged 15-19 years in 2014 worldwide, some 11% (30 million) were already teenage mothers, this study also showed that the average teenage birth rate in developing countries was more than twice as high as that in developed countries (Yasmin, Kumar and Parihar, 2014a). In Europe the rate of teenage pregnancy is prominent among teenage, in the UK the world health organization reported that the teenage pregnancy rate was 19.4% from 1950 to 2010 while in Romania, the teenage pregnancy rate was 29.1% from 2007 to 2014. With further WHO reports, in Australia, teenage pregnancy was 13.1% in 2016 (Wado, Sully, and Mumah, 2019).

In Latin America, a country like Colombia about the national health survey, the proportion of teenage that was pregnant was higher among internally displaced persons than among the teenage population who has not been forced to migrate. Moreover, in Colombia, 13.8% of internally displaced girls aged 15-16 are pregnant, as compared to 7.5% of girls of the same age who have not been displaced. thus, among girls aged 17-19, 36.4% of internally displaced girls have experienced pregnancy, compared to 28.4% of non-internally displaced girls of the same age (Cadena-camargo, *et al.*, 2020).

Africa is the highest with a big number of teenage pregnancy where the first country with the high number of this problem in Nigeria with 203.6 in 100,000 of birth rate, the second is Mali with 175.4, Angola with 166.6, Mozambique with 142.5, Guinea with 141.7, Chad with 137.2, Malawi with 136.9, and Cote d'Ivoire with 135.5 in 100,000 (Nkhoma, *et al.*, 2020). In the

Gambia, the pregnancy among unmarried teenage is a problem and it seems that the possible cause of being pregnant in this teenage age is due to their reproductive health needs which are not being met because having access to sexual and reproductive health information and services by an unmarried teenage from this country is considered as taboo and remains a controversial issue (Abdelsattar, 2016).

The Gambia has a population of 1.791 million with 57% of the population living in the urban areas which makes it more densely populated than the rest of the country (Mchunu, *et al.*, 2012). The percentage of girls aged 15-19 who are married is 25% (Wado, Sully, and Mumah, 2019). The total fertility rate of the Gambia is 5.6 and the number of births per 1000 girls aged 15-19 is 104 (Malaysia, 2018). A study done in Sub-Saharan Africa by Nsimbo in 2015 showed that its regional 4 average birth rate is 143 in 1000 and it is very higher compared to the world average of 65 in 1000 (Abdelsattar, 2016).

In some African countries, about 30 to 40% of teenage girls experience motherhood at age of 18, especially in Nigeria (Campbell, *et al.*, 2013). The literature in 2015 provides another different example of Sub-Saharan African countries with a high prevalence of this problem commonly Ethiopia with a birth rate of 168 in1000, Kenya with 10.5% where only 30.2% are primiparous, Uganda with 25.6% where 15% of teenage pregnancy ends with the termination of pregnancy and Zambia with 22.5% of the incidence of pregnancy (Farber, 2018).

Like The other East African countries, Uganda has a high teenage childbearing rate with estimates at 25% of 15-19 year old having begun childbearing as these levels have remained high in the last15 years despite a decline in the age-specific fertility rate for Uganda among women 15-19 years old (Kassa, *et al.*, 2018). Unfortunately, the younger the teenage mother, the more vulnerable she is both socio-economically and medically to poor outcomes including repeat pregnancies. Not Seldom, Are teenage pregnancies are a result of sexual and gender-based violence (Kassa, *et al.*, 2018). The effects of the COVID-19 pandemic have increased the presence of early pregnancy among teenage, for example in Kenya, media reports state that teenage pregnancies have spiked due to COVID-19 related containment measures, raising concerns about the sexual and reproductive health and long-term schooling outcomes of the vulnerable population. Due to the covid-19 pandemic, a lot of effects have emerged in teenage such as social harm and child marriage (Zulaika, *et al.*, 2022).

In Rwanda there exist also a large number of teenage pregnancies; the typical example is the study done in 2015 by demographic and health survey which showed that the teenage

pregnancy rate has been increasing from 6% to 7% (Uwizeye, Muhayiteto, Kantarama, Wiehler, *et al.*, 2020). However, MoH showed that about 97% of teenage, who get pregnant when they are studying, could not continue their studies. Once again MoH reports that the most cause of teenage pregnancy is poverty accounting for 50% (Gunawardena, *et al.*, 2019). In Rwanda there exist also a large number of teenage pregnancies; the typical example is the study done in 2015 by demographic and health survey which showed that the teenage pregnancy rate has been increasing from 6% to 7% (Uwizeye, Muhayiteto, Kantarama, Wiehler, *et al.*, 2020). This study will show different factors associated with teenage pregnancy among students at G.S Rwamagana as the central core to the prevention of early pregnancy among teenage student girls. Moreover, the study will highlight all corners associated with teenage pregnancy from the family background, the social life of teenage young girls, and economical factors that influence early pregnancy. Fortunately, the presence of additional literature that could help the students, parents, and teachers will enable full awareness and commitment through early pregnancy prevention for the health sake of teenage students.

1.2 STATEMENT OF THE PROBLEM

The increase in teenage pregnancy rates in Rwanda is worrisome, the data from NISR indicate that teenage pregnancy increased from 5.7% to 7.2% of the teen girls countrywide, and from 14% to nearly 21% among young girls aged 19 (Uwizeye, Muhayiteto, Kantarama and Wiehler, 2020). In Rwanda teenage pregnancy is consistently higher in rural areas than in urban areas, however, in 2015, the urban areas came first with 8% of the teens living in town, against 7% presented in rural areas (Uwizeye, Muhayiteto, Kantarama and Wiehler, 2020). The Eastern province presents the highest of teenage pregnancy in recent years from 10% to 11% in 2010 and 2015 respectively. Rwanda in 2015 demographic and health survey showed that the teenage pregnancy rate has been increasing from 6% to 7% (CLADHO,2019). The MoH showed that about 97% of teenage, who get pregnant when they are studying, could not continue their studies (MoH, 2015). Moreover, the study was done in August 2016 at Rwamagana district showed 9.4 % of teenage pregnancies (JIJUKIRWA, 2020) Each year, the Rwamagana district raises and presents this problem of some teenage who gets pregnant in their teenage age (Nkurunziza *et al.*, 2020). Therefore, there is a need to identify the factors associated with teenage pregnancies among the schools of Rwamagana district.

1.3 PURPOSE OF THE STUDY

The study aimed to assess factors associated with teenage pregnancy among secondary students at G.S Rwamagana. The study will contribute to the existence of social factors, economic

factors, and knowledge on reproductive health information as the key factors to early pregnancy among secondary students.

1.4 RESEARCH QUESTIONS

1. What are the demographic factors associated with teenage pregnancy among students at G.S.Rwamagana?
2. What are socioeconomic factors associated with teenage pregnancy among students at G.S.Rwamagana?
3. What is reproductive health knowledge against teenage pregnancy among students from G.S Rwamagana?

1.5 OBJECTIVES OF THE STUDY

1. To determine demographic factors associated with teenage pregnancy among students at G.S Rwamagana
2. To determine socioeconomic factors associated with teenage pregnancy among students at G.S Rwamagana
3. To assess reproductive health knowledge against teenage pregnancy among students from G.S Rwamagana

1.6 SIGNIFICANCE OF THE STUDY

The findings of this research will be important for the different sectors like administration and management, nursing practices, education, and research.

Health sector

The findings of this research will have a contribution to the health sectors where healthcare providers could use it for weighing the extent of the issue; it will also help them to know the cause of related factors of teenage pregnancies. Not only beneficial to the care providers, but it will also help teenage to recognize and be familiar with different associated factors of their unwanted pregnancies. The teenage will increase their awareness for preventing teen pregnancy to promote their wellbeing and ensure the development of the country.

Administration sector

The administrations have the responsibility of protecting their citizen from illness and promoting their well-being, in this way, the findings from this study will help the government

cascade to know the magnitude of teenage pregnancy and set the appropriate measures for fighting against teenage pregnancy in the local area even in all over the country. Also, it will help them to know where to put much effort to ensure well -the being of the citizens.

Education sector

As this study will take place in the education sector, the findings of this study will help the school to highlight different factors that can impede the opportunities of teenage in their studies to ensure their maximum opportunities and school performance, not only that, it will also help teachers to provide appropriate information related to safe protection from the unwanted pregnancy to their students. In addition, most students will have more information related to reproductive health so they will get their full protection from unwanted pregnancies.

Research sector

Above all, we all know that nursing science is dynamic; for this reason, this study will help other students and different researchers in their studies concerning teenage pregnancy. In summary at the end of the project, researchers will provide different recommendations to different levels of Administration including the Ministry of Education, Schools, parents, local leaders, and pastors to ensure awareness concerning teenage pregnancy prevention. Moreover, the study will be used for further deductive research.

1.7 LIMITATIONS OF THE STUDY

The study faced heavy rain for two days that interrupted the presence of participants and their communication with the researchers... Many students live so far away from the school facility in their full participation in the study inhibited the fullness. The teenage manners and behaviors delayed answers and misinterpret questions included in the questionnaire and as well as skipping of the misunderstood questions not asked instead.

1.8 SCOPE OF THE STUDY

Location

Groupe Scolaire Rwamagana is located in Eastern province, Rwamagana district, Kigabiro sector, Nyagasenyi cell, Rusave village.

Participants

Groupe Scolaire Rwamagana is twelve years basic education which holds 1008 students in total. Young Girls are 643; Young boys are 465 and 32 teachers. The study will involve teenage girls who study in Secondary school in the age range of 10 to 19 years old. Who are the central

face of pregnancy in Rwamagana district and G.S Rwamagana as well, and it is more necessary to involve young girls as the precursors of the pregnancy at young ages which unfortunately impairs their well-being.

Timeframe and field

The study was carried out in the Rwamagana secondary school facility and involved young teenage girls. As for the time, the focus of this research is relative to 6 months (July 2021–February 2022.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter highlights the definition of key concepts, teenage pregnancy as an issue, and description of teenage pregnancy, empirical literature review, and Conceptual framework.

2.1 Definitions of key concepts

Teenage

It refers to the person between ages 10 and 19 years (Federation, *et al.*, 2016).

Pregnancy

It refers to the time during which one or more offspring develops inside a woman (Obrowski, 2016). Pregnancy is also defined as nine months for which a woman carries a developing embryo and fetus in her womb (Leung, 2004).

Teenage pregnancy

It refers to the pregnancy of girls during their teenage age(WHO, 2013).

Pregnant Teenage

It refers to a woman between the ages of 10 and 19 who conceives (Yasmin & Kumar, 2014).

Factor

It refers to something which contributes to the results (Report, 2009).

Explore means to go into or through for purposes of discovery or adventure (Honig, 2015).

Associated factor

In medicine, an associated factor is something that makes a connection between things or concepts (Report, 2009). For example, HIV is an associated factor of TB, people living with HIV are 15-22 times more likely to develop TB than persons without HIV (ICPD, 2013).

2.2 TEENAGE PREGNANCY AS AN ISSUE

Many years ago teenage pregnancy was considered normative, where different societies from different countries found teenage childbearing as an advantage for family and even for the countries (CDC, 2017). In this way some countries started to express the extreme increase of teenage pregnancy, for example, the western societies over the last century were having a high incidence rate of sexual intercourse among teenage, unfortunately, the number of teenage pregnancies became sharply increased (UNICEF, 2018). And this was the reason why the problem of teenage pregnancy was taken after the Second World War. Later in the 1960s and 1970s, many societies and health authorities continue to view the growing number of teenage pregnancies as a huge problem however they were not yet with the solution (Franjic, 2018). In 1960 different police makers continue to think about teenage pregnancy and their solutions by

1965 different health and medical researchers commonly Deborah Rhode, Constance, Banfield in 1974, Murray in1984, Nathanson in 1991, Kristin Luker in1996 and Wilson in 2002 started and some of them continue to realize the consequences and to found out the solutions of teenage pregnancy (Furstenberg, 2007). In 1965 10 the term teenage pregnancy was termed as teenage parenthood or as teenage mothers (Winnable and Final, 2015).

By 1995 president of America" Bill Clinton" raise teenage pregnancy as a serious social issue after Jimmy Carter's Administration and at this time every president was encouraged to put the issue into the agenda because of rapid childbearing by the teenage, and this was already considered as the main cause of an increase for demand to the public assistance and other services for single mothers(Honig, 2015). This happened after finding that California had two over five teenage pregnancies, therefore in 1997 National Campaign in preventing teenage pregnancy arrived and continue to put into place their objectives and to communicate the issue to work together with different agencies for fighting against teen pregnancy (UNFPA, 2018). Then the problem was continuing from America to the Philippines, and later to developed countries as well as developing countries until now, nowadays the problem is extremely high even if different countries are implementing different ways to weaken the issues (Early et al., 2016).

2.3 DESCRIPTION OF TEENAGE PREGNANCY

As said before teenage pregnancy is any pregnancy that happened between 10 and 19, Some literature showed that this teenage age is when some girls are at high risk of getting pregnant as their body physiological changes occur, during the age of teenage Piaget explained that teenage have more curiosity on sexual intercourse mainly in stage of formal operational thinking and it is where girls developed rapidly and her body parts become developed and more active, among those parts include breast, mom's pubis, first menstruation, increased thigh in size as well as an increase in hormone levels of function (Nations & UNICEF, 2011).

Therefore, the literature showed that all those changes contribute to a high risk for engaging in early sexual intercourse where they can also get risk for pregnancy(CRC, 2018). The other literature said that social deprivation such as poverty play role in a big number of teenage pregnancy (UNICEF, 2018). In addition for some countries with a high prevalence of HIV infections, many teenage is at high risk for HIV infection, however in developed countries where abortion is allowed most teenage pregnancy ends in abortion (DHS, 2017).

Other literature had said that teenage pregnancy increases risk in their children like physical abuse, congenital malformation, infant mortality, and morbidity as well as malnutrition (DHS, 2017). Despite their children but also teenage mothers experience a high risk of hypertensive disorders, preterm, anemia, and maternal morbidity and mortality are more common in teenage (Maly, *et al.*, 2017). Moreover, the literature highlighted that cesarean section is more common in teenage during their birth due to their chronological age and gynecological age and their pregnancies cause immaturity of pelvic bone which results in obstructed labor (Abebe, *et al.*, 2016).

Different kinds of literature talked about the factors associated with teenage pregnancy and they categorized them into three main groups mainly demographic, Economic, and social factors (CLADHO,2019). Therefore they stated that demographic factors commonly age, sex, education level, income level, marital status, occupation, religions, birth rate, death rate, the average size of family, and the average age at marriage, play a big role in teenage pregnancy (CRC, 2018). Considering age, the study done in Lindi in Tanzania showed that age of most teenage started and become sexually active at the age of 9 and 19 years old, also about 25% of girls at age 13 are more sexually active and have already done sexual intercourse while at age of 16, 27% of teenage girls had sexual intercourse (Walag, *et al*., 2018).

Another study done on associated factors of pregnancy in teenage in sub-Saharan countries showed that in Western and Eastern the percentages of girls who started their sexual intercourse in their teenage age are 83% and 65% respectively(ICPD, 2013). The study done in Tunduru from Tanzania showed that the teens were having low knowledge which put them far from reproductive health information and may fall into unwanted pregnancy (UNICEF, 2012). The study from Lusaka noticed that the majority of teenage pregnancy occurs at age 15 with 21.1% (CRC, 2018). Also, some studies took religions as a key factor in teenage pregnancy. CCCN, 2017 indicated that some religions encourage early marriage.

However the study done in Sub-Saharan Africa, rural residences increase the likelihood of getting unwanted pregnancy by 35% than urban area of 20% and the reason is that the girls from the rural area don't get easy access to the health information and health services and also being ashamed to attend reproductive health services(DHS, 2017). The study done in Lusaka by Langham show that among teenage pregnancy 54% are uneducated girls and 46% are educated with secondary school 15%, thus being uneducated increase the risk of getting pregnant among teenage (DHS, 2017).

Shittu in 2013, found that some countries encourage early marriage, he provided an example of Niger where 65 % agree with early marriage and he also showed that in Lusaka 60% of teenage are legally married (Gunawardena, *et al.,* 2019). (). Some literature stated that some beliefs discourage teenage from not getting health services like contraceptives (Early *et al.,* 2016).

WHO,2013 indicated that economic factors such as poverty, low-income level, and unemployment play a big role in teenage pregnancies, and it stated that about 16 million each year,99% birth of teenage are from both low and middle-income countries and average birth rate in middle-income countries is double when compared to high-income countries (CCCN, 2014). Konk, E.X,2016 said that unemployment and low-income levels for teenage can contribute to being unsatisfied, and then they fall into a sexual relationship for finding additional amount to satisfy their needs, by this time they can get pregnant as they can have forced unprotected sexual intercourse (CCCN, 2014).

WHO,2013 also highlighted that social factors such as broken homes, single parents, peer pressure, lust, rape& sexual abuse, alcoholism & drug abuse, pornography, lack of reproductive health information, lack of parental guidance, lack of knowledge, and lack of education can contribute to the risk of getting pregnant for some teenage girls(Abdelfattah, 2016). CDC,2017 had realized that a broken home which takes place after divorce or death of one to two parents may lead to little parents love and affection as children may remain with no control without any advice from their parents and this can lead to unwanted pregnancy (Glynn, *et al.*, 2018).

Sethia,2017 said that peer pressure on some teenage can increase the risk of being pregnant as peer pressure make them unaware of contraception, and also it encourages teens to be in a boy-girl relationship which acts as a favor in engaging in an early sexual relationship and unwanted pregnancy (Presler-marshall& Jones, 2012). CCCN, 2017 in its study showed that physiological and physical change and feelings of teenage boys and girls may put them at the risk of engaging in early sexual intercourse as they are sexually active, and unwanted pregnancies often result from this change(DHS, 2017).

Statistics in 2015, reported that 51% of all unwanted pregnancies among teens were from sexual abuse and 44% from rape victims. It also showed that 49% of teenage pregnancies were from their colleagues, 20% from family members,2% from tutorials and1% from local leaders, additionally 75% and 25% were sexually violated and voluntary sexual intercourse respectively (Nkurunziza, *et al.*, 2020). Some studies indicated that alcoholism and drug abuse, about 75%

of teenage pregnancy occurs due to teen drinking because after drinking too much alcohol they lost control (CRC, 2018).

Pornography videos and photos available on the internet increase risk for some teenage of engaging in early sexual intercourse to satisfy their curiosity which may result in unwanted pregnancy(Honig, 2015). Lack of parental guidance had been linked to teenage pregnancies as most parents used to be busy in their work and don't care about the children; this had been indicated also as a key factor in teenage pregnancies (CLADHO,2019).

However, even if the problem of teenage pregnancies is still increasing and with irreparable consequences which violate the rights of girls, with life-threatening consequences in terms of sexual and reproductive health and posing high development costs for communities particularly in perpetuating the cycle of poverty, researchers indicated that some teenage know those irreparable consequences from teenage pregnancies (Campbell, *et al.*, 2013). There also exist some preventive strategies for teenage pregnancies, the strategies include being educated by their parents about their body parts, similarities, and differences between girls and boys during puberty (Nkurunziza *et al.*, 2020).

Teachers in health courses often explain clearly the effects of drinking alcohol on teenage and how the brain is behaving during heavy drinking (Molina & Gonzalez, 2014). The teachers also discuss with their students on effects of peer pressure that can lead 15 to unprotected sex (CRC, 2018). some adults approach their children as they approach puberty and talk with them openly about the surge hormones they experience, strong emotions, and sexual feelings (CLADHO,2019). And some teenage know and believe that the use of contraceptives and being abstinence are major ways to prevent teenage pregnancies (Neal, *et al.*, 2020).

2.4 EMPIRICAL LITERATURE REVIEW

In many countries large numbers of teenage pregnancy and childbirth are reported, this is more common in developing countries than in developed countries where the incidence occurs in various regions of countries (Powers, 2020).

As, it was said before the problem is highlighted in both developed and developing countries, therefore the United Nations Development Report's 2018 Statistical Updated ranks for each country in the world based on their HDI ranking. It reported that developed countries are also encountered a high rate of teenage pregnancies (Farber, 2018). The research from these

developed countries indicates that there exist 20,000 girls under 19 years who give birth every day, by taking this number and multiplying by average annual days of 365, we get seven million and three hundred thousand (7,300,000 girls) annually from only developed countries (Prasad, *et al*., 2015).

UND, 2018 showed that in developed countries, technology occupied 17.9% of teenage pregnancies where they often spent many hours in pornography videos from youtube, Facebook and WhatsApp. The most developed countries which are faced with this problem are China and India where 20% and 16% of teenage pregnancies are for India and China respectively, and they account for more than one-third of the global total (Gayatri, 2021). The study done in china on exploring associated factors of teenage pregnancies showed that age and curiosity of sexual intercourse contributed to teenage pregnancies at the rate of 47.9%, poverty occupied 21.4%, unemployment 0ccpied 11.3%, being uneducated occupied 9.4%, early marriage with 3. 11%, rape and sexual abuse with 5.1%, and the rest factors shared 1.79% (CCCN, 2014).

The third developed country which might be taken as an example is the USA with 67.8 in 1000 teenage pregnancies (Fears, 2016). In the U.S.A literature showed that peer pressure occupied 31.7%, alcoholism and drug abuse occupied 20.3%, broken houses occupied 16.9%, rape and sexual abuse with 9.2%, poverty 7.9%, lack of sexual education with 3.6% and the rest factors shared 10.4% (CDC, 2017). While developing countries like the Gambia, sub-Saharan countries, Nepal, Zimbabwe, Nigeria, South Korea, Argentina, Philippines, and Rwanda showed an estimated number of 23 million teenage girls who give birth in their teenage age (Nkhoma, *et al.*, 2020).

The most developing countries faced with teenage pregnancies are the Gambia with 25% teenage pregnancy, also from South Korea 2.9 in 1000 of teenage each year become pregnancy and sub-Saharan countries occupy 143 per 1000 accounting 14.3%, the other developing counties might include Nepal and Zimbabwe with 21% and 32.8% of teenage pregnancy respectively (Neal *et al.*, 2020). According to the study done in tundra from Tanzania showed that about 60% of teenage pregnancies are due to poverty, followed by lack of access to reproductive health services with 23.9% and lack of knowledge and parent guidance with 11.8% (UNFPA, 2018).

A study done in Sub-Saharan Africa by Nsimbo in 2015 showed that its regional average birth rate is 143 in 1000 and it is very higher compared to the world average of 65 in 1000, each year one out five i.e. 1/5 of girls are mostly like to give birth at the age 19, means that almost girls

are likely to have birth at her teenage age, Also in some African countries about 30 to40% of adolescence girl experience motherhood at age of 18 especially in Nigeria (Neal, *et al.*, 2020). In Nigeria, the literature showed that religion and poverty contributed to teenage pregnancies at the rate of 38.8% (Walag, *et al.*, 2018).

The literature in 2015 provides different examples of sub-Saharan African countries with a high prevalence of this problem commonly Ethiopia with a birth rate of 168 in1000, Kenya with 10.5% where only 30.2% are primiparous, Uganda with 25.6% where 15% of teenage pregnancy ends with the termination of pregnancy and Zambia with 22.5% of the incidence of pregnancy (Ahinkorah, *et al.*, 2021). In Kenya study showed that orphanhood occupied 35.7% of teenage pregnancies (UNICEF, 2018). In the middle East and North Africa, the study showed that the regional average birth rate of 56 in 1000(15-19), the examples of some countries are Israel with 19 in 1000, Kuwait with 31 in 1000, Saudi-Arabia with 114 in 1000 and Sudan with 52 in 1000 (UNICEF, 2018).

In Kuwait, the literature showed that poverty occupied 65.2% of teenage pregnancies, and also myths and beliefs related occupied 16.4% (Maly, *et al.*, 2017). In central Asia, its regional average birth 59 in 1000, and East, South Asia and Pacific with average birth 56 in 1000, the examples of these countries include Bangladesh with 69%, India with 107 in 1000, Pakistan with 89 in 1000, Srilanka with 9.8%, Australia with 38.3 in 1000 and New Zealand with 34 in 1000 (WHO, 2014). In Pakistan, the major cause of teenage pregnancies is unemployment which occupied 55.9% and it was followed by a lack of parental guidance (Yussif, *et al.*, 2017).

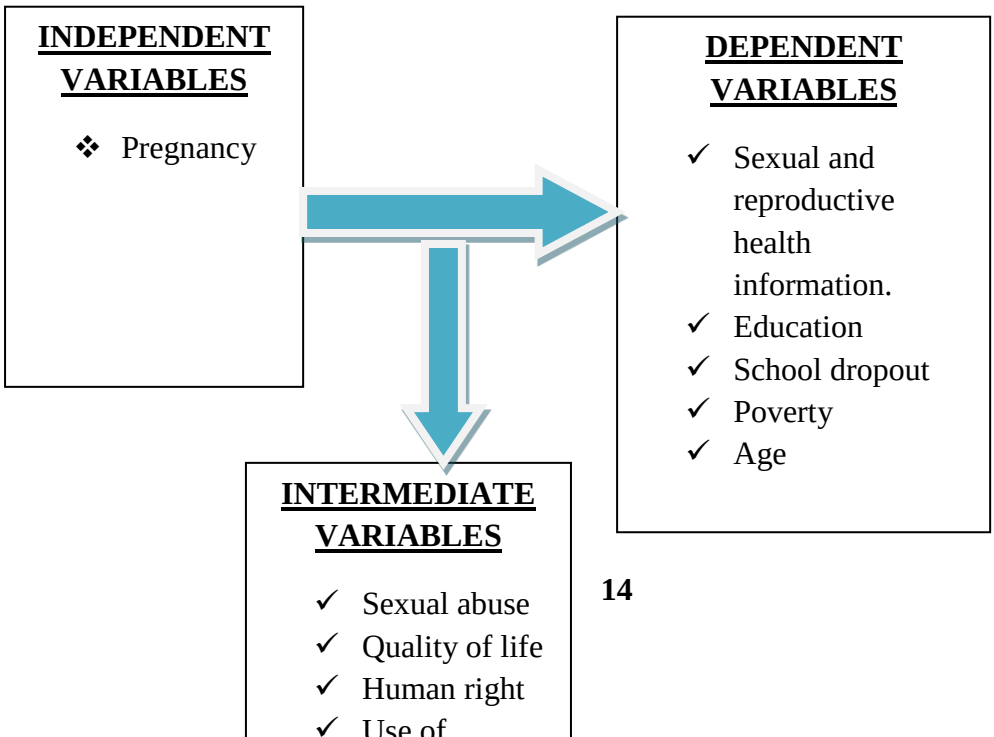
In Europe study showed that its regional average of 25 in 1000 different examples are Ireland with 16 in 1000, Portugal with 9 in 1000, Scandinavian countries with 20 in1000, and United Kingdom with 45 in 1000 (CDC, 2017).In Latin America some examples of Mexico with 84 in 1000 and Brazil with 71 in 1000. The study showed that North America with 83.6 in 1000 pregnancy rate, 29.2 in 1000 abortions, and 54.4 birth rate (Macleod, 2014). In Scandinavian countries, single parenthood and orphanhood with 25.8% had been identified as major factors of teenage pregnancies (Klein, 2018).

Literature showed that different countries had decided to teach teens about reproductive health, to increase their awareness (Kyilleh, Tabong, and Konlaan, 2018). Common reproductive health they often taught include the use of contraceptives as a part of family planning, avoiding peer pressure, prevention of STIs, and knowing the physiological change of their body at teenage age (Kyilleh, Tabong, and Konlaan, 2018). About 79.1% worldwide of teenage are

often taught reproductive health (Klein, 2018). In Africa, some studies showed that 56.9% of teenage have access to reproductive health, and this is more common in educated and urban teenage (Habte *et al.*, 2022). However, in Rwanda, only 41.5% are familiar with and nearby to reproductive health knowledge (FHI 360, 2013)

Despite the frequency of teenage pregnancy, the literature showed that 38.1% worldwide of teenage know the impacts of teenage pregnancies and about 33.5% in Africa of teenage know irreparable consequences from teenage pregnancies (CDC, 2017). Also, the study done in Rwanda 2016 by CLADHO showed that only 31% have knowledge on child rights, 23% on human rights principles, 13% reported that they know Teenage-Sexual and Reproductive Health, and 22% on Sexual and Gender-Based Violence (UNFPA, 2018).

2.5 CONCEPTUAL FRAMEWORK



The unplanned pregnancy at an early age is prominent in the young generation and results from different perspectives such as social, economic, and reproductive health cascade. Unfortunately, these worldwide problems affect the mental health and future of the young girls in the way that they drop out from schools as they lose better education, as well as the gate to consistent poverty. Moreover, this is always based on the lack of sexual and reproductive health information in the early age of teenage girls in which parents are not used to bringing sexual conversation out openly as a result of culture, religion, and lack of knowledge. Thus, the problem has to be with sexual abuse penalties and prevention for the health's sake of the young generation. Different organizations such as government services have to work hand in hand in collaboration for the right of young girls. The government through means of health services has to empower clubs and different teaching that booster hope from the lost young generation.

CHAPTER 3 RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter is dealing with research methodology, it describes the research approach and design, target population, data collection procedures, and instruments used during research. It provides information about materials, study area descriptions, and methods used to carry out this study.

3.1 RESEARCH APPROACH

The study used a descriptive cross-sectional study design and a quantitative approach. The cross-sectional study involved looking at people who differ on one key characteristic at one specific point in time.

3.2. TARGET POPULATION

The total population is 256 secondary school students of G.S.Rwamagana.

3.3 SAMPLING PROCEDURES

The study used a simple random sampling technique with an equal chance of all teenage young girls. They were therefore given papers written of countable numbers and each one was allowed to pick the number. Finally, those who picked a paper with an even number count were assigned as participants of the study.

3.4 SAMPLE SIZE

The researchers worked in their collaboration on at least 326 students with all inclusion criteria. As teenage girls are more vulnerable to worsening effects of unwanted pregnancy, therefore the number of girls doubled the number of boys. The sample size was calculated using the formula of Taro Yamane, where the confidence interval is 95% and the margin error of 5% (Yamane, 1967). With, N=study population n=simple size, e=constant number =0.05

n=$\frac{N}{1+N(e)^2}$ N=100, then n= $\frac{326}{1+326(0.05)^2}$

n=179.61≈ 180

3.5 RESEARCH INSTRUMENTS FOR DATA COLLECTION

This study was quantitative in data collection self-administered questionnaires used. The questionnaires were composed of two sections, the first section contained demographic data of respondents, and the second section with the questions related to associated factors of teenage pregnancy. Other tools are Papers, Pens, Pencils, Erasers, Pencil sharper, Stepper machine, Agraffe, and Flash disk.

3.6 DATA COLLECTION AND PROCEDURES

The researchers have to translate the questionnaire from English into Kinyarwanda for a better and common understanding of participants and Data was collected in the 4 days that the researchers and direction of G.S Rwamagana did choose, the first 2 days, there was the time of requesting and obtaining the permission and the informed consents from the school authority and the collection of the questionnaires that were used. The researchers also discussed with the school authority about the well-structured timetable that was used during data collection. Clear explanations, the objectives, the significance, and the inclusion criteria of the study were given to the school authority and the participants of the study. In the two last days, the questionnaires

were distributed among the participants and the information was collected by the researchers by considering the ethics of the nursing profession.

3.7 ETHICAL ISSUES

A. Permission

The study required ethical approval from the research committee of Kibogora Polytechnic to conduct the study and as well as a permission letter from the Headteacher of G.S Rwamagana that allow us to conduct a study in the school he is heading.

B. Consent and confidentiality

The participants were explained that they have the right to withdraw from the study and it was voluntary to accept to be a part of the study before signing consent forms. The students who were interested in participating in the study were identified and signed the consent forms. The research participant's anonymity and confidentiality were assured by giving a code to each participant and using their codes instead of their names when filling out the questionnaire. Responses were strictly confidential and the filled questionnaires were kept in a locked filing cupboard in one of the researcher's rooms and the data in soft copy was saved in separate password-protect computer files to be accessed by only the researchers and research supervisor.

C. Beneficence and right to self-determination

The participants of the study were explained that they have the right to self-determination and that the study is a part of academic requirement and data that were obtained were for research purposes only and was kept confidentially. The research purpose and its significance, nature of the questionnaire, and procedure to use when collecting data were explained to them.

The participants were explained that it is voluntary to take part in the study with the right to withdraw or withhold information at any time without any consequence. The researchers were reassured that there is no potential risk from contribution and that everyone had an equal chance to be selected for the study to meet the needed sample. In addition to that, the participants were informed that there is no compensation in terms of money or any gifts associated with participation in the study.

3.8 DATA ANALYSIS

A. Data analysis

After data collection, immediately the information was entered into the computer machine to be analyzed. Data were analyzed by using a statistical package for social sciences (SPSS) to be quantitatively analyzed. The analyzed data were expressed in frequency and percentages.

3.9 RELIABILITY AND VALIDITY MEASURES

In our study validity was ensured when organizing the items of the questionnaire against the research objectives. The questionnaire was developed and approved to identify associated factors of teenage pregnancies among secondary students at G.S Rwamagana and it was also adapted to fit the Rwandan perspective and was fairly easy to read to all participants as well as making sure of the consistency of the collected data.

To make sure of the reliability of the questionnaire a sample of participants with the same criteria as that of teenage from the central site was given the questionnaire to pre-test and check the consistency and believed proper fulfillment as well as adaptation to the questionnaire.

In the data collection tool, we avoided using complicated and confusing words, and the questionnaire was possibly translated from English to our mother language (Kinyarwanda) by the expert in English-Kinyarwanda with understandable words and the researchers were pre-test the questionnaire before conducting the main study.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS, INTERPRETATION, AND SUMMARY

4.0 INTRODUCTION

This chapter presents and analyses the findings through data gathered in G.S Rwamagana. And the chapter focuses on the socio-demographic characteristics of respondents, the Family background of the teenage, Economic factors associated with teenage pregnancy, as well as Sexuality and reproductive health. The presentation of the findings is done according to the study objectives and research questions formulated to guide this study. Data are presented and analyzed using frequency and percentages which were collected through means of questionnaires. And also, this chapter deals with the use of SPSS through data analysis. Furthermore, the respondents are teenage students aged between 10 to 19 years old. Thus, to test the study objectives, data were analyzed in line with answers given according to the

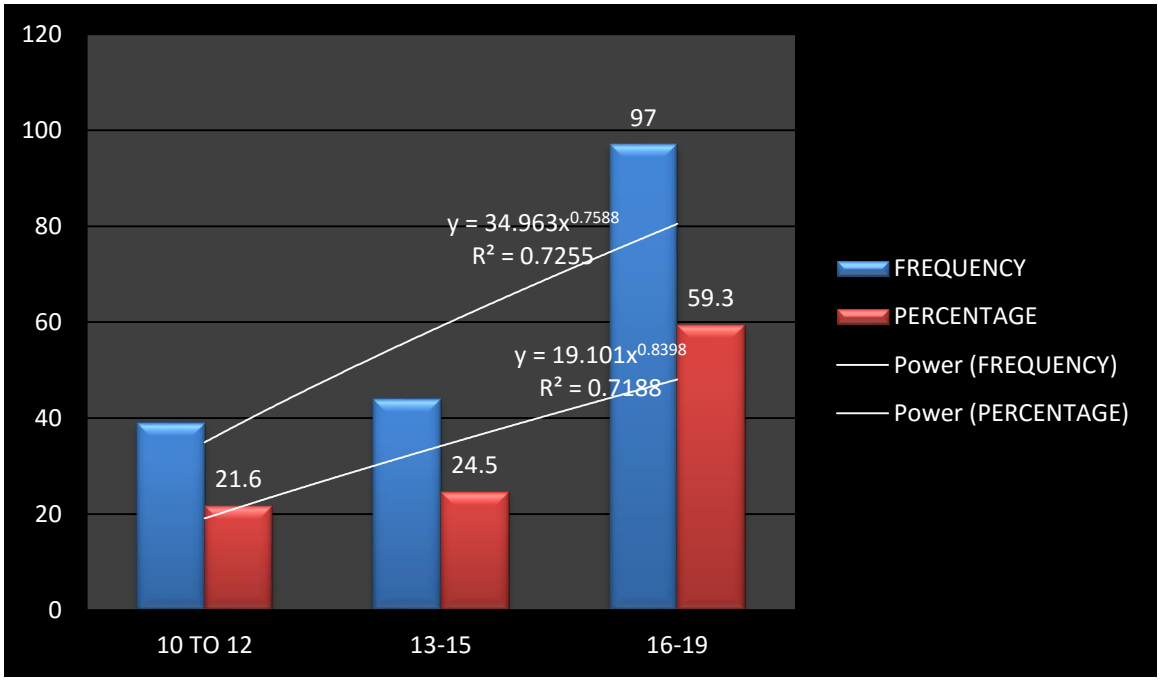
research objectives in which 180 teenage students were used to fill the questionnaire in data collection, the whole 180 questionnaires were filled at the rate of 100%.

4.1 PRESENTATION OF THE FINDINGS+ INTERPRETATIONS

4.1.1. SOCIO-DEMOGRAPHIC INFORMATION

Variables	Value	Frequency	Percentage
Age range	10-12	39	21.6
	13-15	44	24.5
	16-19	97	59.3
Religion	Catholic	73	40.6
	Moslem	36	20.0
	Protestant	71	39.4
Residence	Rural	139	77.2
	Urban	41	22.8

4.1.1 Graph on Age range



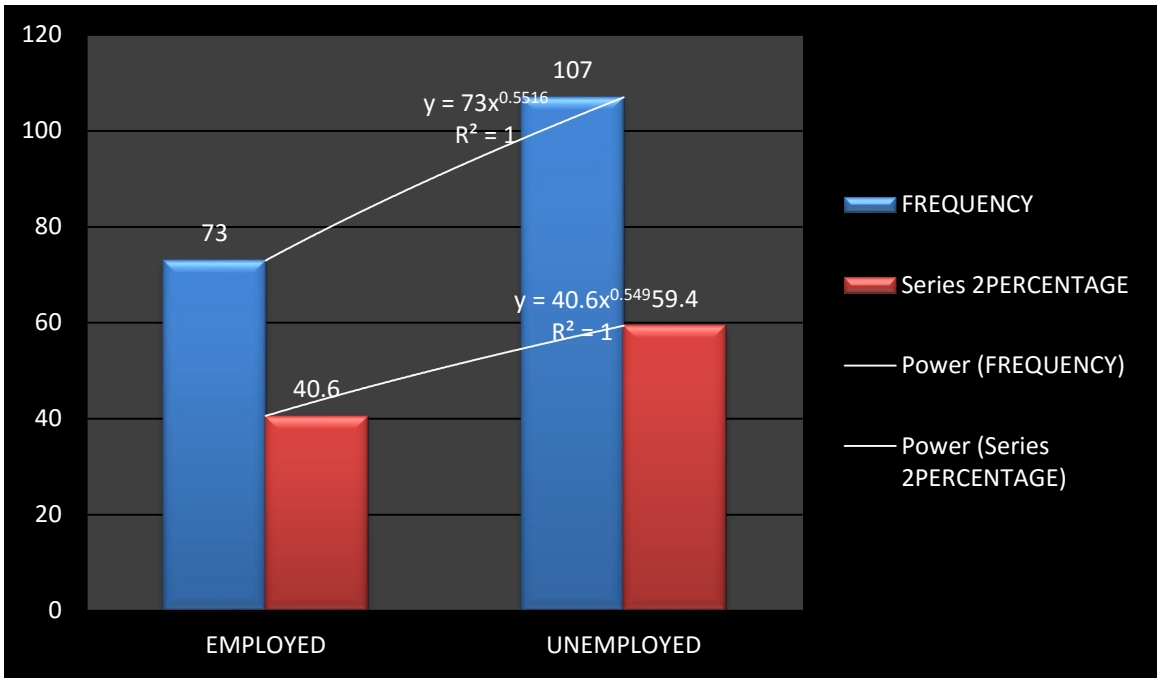
GRAPH 4.1.4 1

Table 4.1 describes the socio-demographic information of teenage. The teenage with the age of 18 with a proportion of 1(6%), where, 10,12,13,17 presented with the lower proportion of 2(1.1%). and 11 years old presented in 35(19.4%), 16 years old presented with 32(17.8%), 14 years presented with 39(21.7%). and 19 years teenage presented in larger proportion with 62(34.4%). When asked about religion Muslims presented in lower proportion with 36(20%) followed by Protestants with 71(39.9%) and catholic teenage girls presented in highest proportion with the proportion of 73(40.6%). When asked about the place of residence 139(77.2%) live in rural areas of Rwamagana district and only 41(22.8%) presented in the least proportion of urban areas residence. When asked whether their parents attended formal education, parents on the level of primary presented with 45(25.0%) followed by those of 68(37.8%) as the level of secondary school and the university fall in the proportion of 67(37.2%). And when asked whether getting married before 15 years of age is good, those who said no presented in larger proportion with 106(58.9%) and followed by those with yes fall with 74(41.1%)

4.1.2 ECONOMIC FACTORS ASSOCIATED WITH TEENAGE PREGNANCY

Variables	Value	Frequency	Percentage
Father's occupation status	Employed	73	40.6
	Unemployed	107	59.4
Mother's occupation status	Employed	110	61.1
	Unemployed	70	38.9
Adequate support from parents	Yes	80	44.44
	No	100	55.55
If not married, do you get any financial support from your boyfriend?	Yes	113	62.8
	No	67	37.2
Do you depend on that support?	No	152	84.4
	Yes	28	15.6
Does he give you much more financial support than your need?	Yes	27	15.0
	No	153	85.0

4.2.1 GRAPH ON OCCUPATION STATUS



GRAPH 4.1.4 2

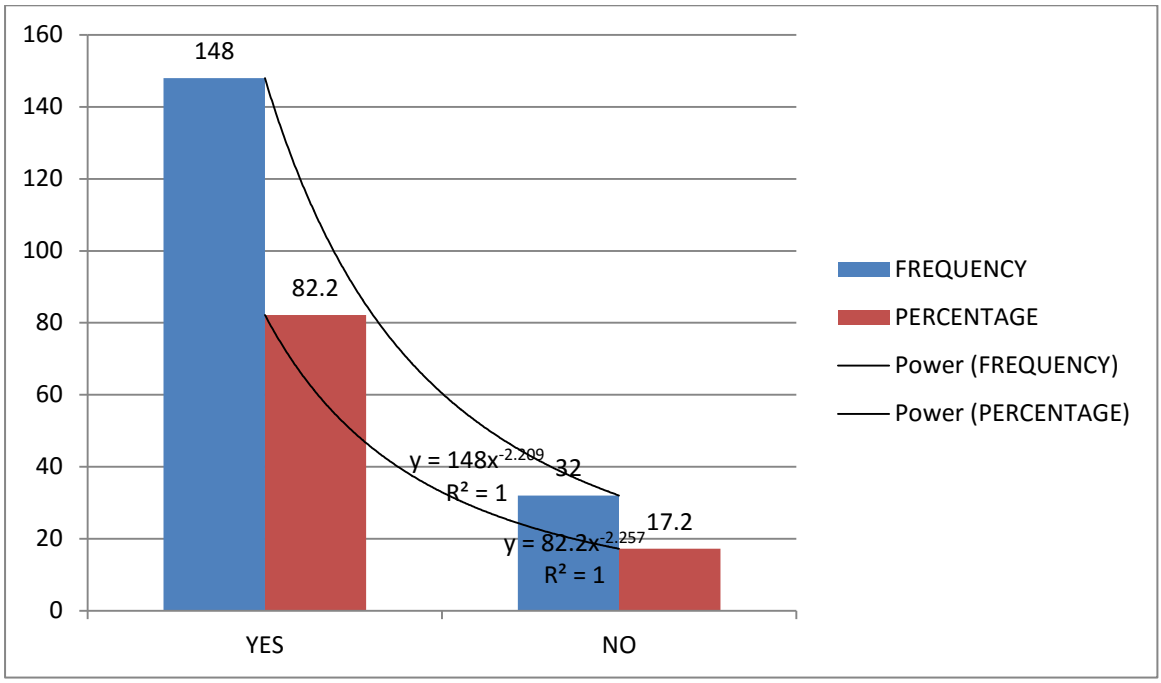
Table 4.1.2 Describes economic factors associated with teenage pregnancy. When asked about the occupation of their father, only 73(40.6%) had employed fathers and 107(59.4%) had unemployed fathers. When asked about the occupation of their mothers, 110(61.1%) had employed mothers and 70(38.9%) had unemployed mothers. When asked whether they have ever engaged in sex for money, those who said were 67(37.2%) and the majority had engaged in sex with the proportion of 113(62.8%). When asked whether parents offer adequate support at home or school, only 67(37.2%) do receive usual support from parents.

4.1.3 SOCIAL FACTORS ASSOCIATED WITH TEENAGE PREGNANCY

Variables	Value	Frequency	Percentage
Live with	Mother	164	91.1
	Both F/M	13	7.2
	Guardian	3	1.7
Sexual intercourse	Yes	100	55.55
	No	80	44.45
Alcohol Drinking	Yes	146	81.1
	No	34	18.9
If yes, who has influenced you	Peers	92	51.1

	Boyfriend	88	48.88
Access to reproductive health information	No	32	17.2
	Yes	148	82.2
If the answer is no, what seems to be an obstacle?	Parents	150	83.33
	Religion	30	16.66

4.1.3 GRAPH ON REPRODUCTIVE HEALTH INFORMATION



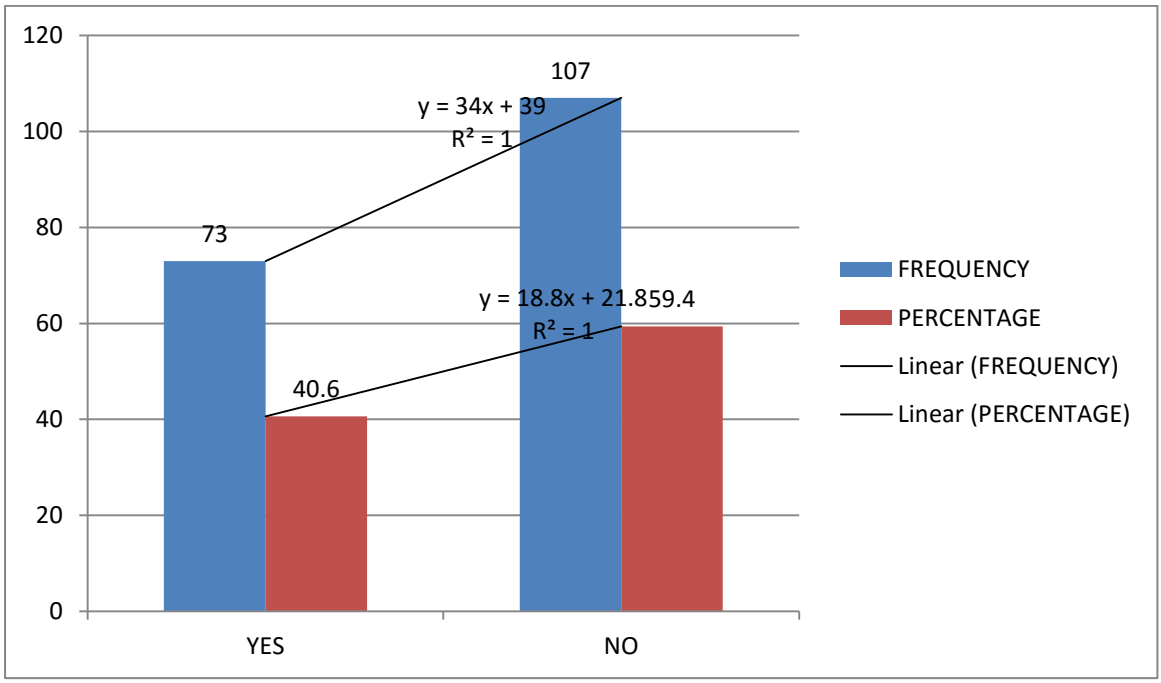
GRAPH 4.1.4 3

Table 4.1.3 Describes social factors associated with teenage pregnancy, when asked whom they live with, mothers only occupied 164(91.1%) followed by those who are taken care of by guardians 3(1.7%) and those with both parents are 13(7.2%). when asked whether they have ever had sexual intercourse, those who said yes were 100(55.55%) followed by those who did not ever have sexual intercourse were 80(44.45%). When asked whether they have been forced sexual intercourse only 20(11.1%) had experienced that manner and 160(88.8%) were free of sexual intercourse. When asked whether they get easy access to reproductive health information, those who did not were 32(17.8%) whereas the large number were those with 148(82.2%) get access to sexual and reproductive health information. When asked whether they use any contraceptive methods in the prevention of pregnancy, 107(59.4%) do not use any and 73(40.6%) use contraceptive methods. When asked whether parents like to discuss their reproductive health, 111(61.7%) do not get reproductive health discussions with their parents but only 69(38.3%) do get planned reproductive health discussions with their parents.

4.1.4 PREVENTION STRATEGIES FOR TEENAGE PREGNANCIES AND REPRODUCTIVE HEALTH KNOWLEDGE

VARIABLES	VALUE	FREQUENCY	PERCENTAGE
Use of contraceptives	No	107	59.4
	Yes	73	40.6
Contraceptive methods use against pregnancy and STIs/HIV/AIDS	Condom	110	61.1
	Pills	34	24.3
	Injection	36	20.0
Have you been pregnant	No	171	95.0
	Yes	9	5.0
Risks of indulging in sexual intercourse at an early age	Pregnancy	110	61.11
	STI/HIV/AIDS	70	38.99
Have you ever had sexual intercourse	No	109	60.6
	Yes	71	39.4
When is a girl likely to get pregnant?	14 days before menstruation	179	99.4
	During menstruation	1	6
What physical changes do girls notice during puberty	Pubic hair growth	130	77.7
	Starting of menstrual period	50	22.3
How do you get reproductive health information	From internet	16	8.9
	From health facility	43	23.8
	School clubs	3	1.6
	From radio	82	40.3
	Centre de Jeunes	15	8.3
	From television	21	17.1
Do you easily access reproductive health information	No	32	17.8
	Yes	148	82.2

4.1.4 GRAPH ON CONTRACEPTIVES USE



GRAPH 4.1.4 4

Table 4.1.4 describes the teenager's knowledge of reproductive health and prevention strategies for teenage pregnancy. When asked whether they have ever had sexual intercourse, the majority were 100(55.55%) experienced sexual intercourse at an early age while only 80(44.45%) were free of sexual intercourse with denial reply. When asked whether they get easy access to reproductive health information, all 148(82.2%) said no while only 32(17.8%) said yes as a means of easy access to reproductive health information. And if the answer is no, what seems to be an obstacle, as results parents as obstacle were 150(83.3%) whereas religion as an obstacle was 30(16.7%). When asked on how they get sexual reproductive and health information, those who get information from television presented in the lowest proportion of 21 (17.1%) followed by who get information from the internet 16(8.9%) and the majority were 143(79.4%) who get information from radio. And when asked what physical changes do girls notice during puberty, those who said the growth of pubic hair was 130(77.7%) followed by those with 50(33.2%) who had started yet menstruation period. and with all 180 participants, all 176(97.8%) had menstruation period while 4(2.2%) had not yet had menstruation period. when asked when a girl is likely to get pregnant, only 10(5.5%) think during the menstruation period they can get pregnant. And when asked about risks of indulging in sexual intercourse at an early age, 79(43.8%) take the risk in the image of STI/HIV/AIDS while all 101(56.11%) look

at pregnancy as the risk factor of health deterioration when occurs in the earliest age. Finally, concerning early pregnancy prevention, when asked about the use of contraceptives and only 73(40.3%) use contraceptives against early pregnancy while all 107(59.4%) do not use any artificial contraceptives but indeed apply abstinence as the church oblige. And when asked about the method of use to prevent both pregnancy and STIs, the lowest proportion presented as a use of injection with 34(24.3%) followed by those who use pills 36(20.0%) and the majority who use a condom as preventive majors were 110(61.1%).

4.2 SUMMARY OF FINDINGS

The study involved 180 teenage young girls in the age range between 10 to 19 years old, it is indeed shown that teenage face factors are associated with teenage pregnancy in which32 (17.8%) do not get access to reproductive health information. and all 100(55.55%) had sexual intercourse experience. About economic factors associated with teenage pregnancy, 107(49.1%) had unemployed fathers and those with unemployed mothers were 70(38.9%) which might be the precursors to the unintended pregnancy about the lack of basic needs and as result, the social factors associated with teenage pregnancy among young girls were 102(56.66%) where else, the economic factors associated with teenage pregnancy were 80(44.44%). Whereas with the respect to their knowledge and prevention cascades, when asked on how they get sexual reproductive and health information, those who get information from television presented in the lowest proportion of 21 (17.1%) followed by who get information from the internet 16(8.9%) and the majority were 143(79.4%) who get information from radio. And when asked what physical changes do girls notice during puberty, those who said the growth of pubic hair was 130(77.7%) followed by those with 50(33.2%) who had started yet menstruation period. and with all 180 participants, all had menstruation period while 4(2.2%) had not yet had menstruation period. when asked when a girl is likely to get pregnant, only 10(5.5%) think during the menstruation period they can get pregnant. And when asked about risks of indulging in sexual intercourse at an early age, 79(43.8%) take the risk in the image of STI/HIV/AIDS while all 101(56.11%) look at pregnancy as the risk factor of health deterioration when occurs in the earliest age. Finally, about early pregnancy prevention, when asked about the use of contraceptives and only 73(40.3%) use contraceptives against early pregnancy while all 107(59.4%) do not use any artificial contraceptives but indeed apply abstinence as the church oblige. And when asked about the method of use to prevent both pregnancy and STIs, the lowest proportion presented as a use of injection with 34(24.3%)

followed by those who use pills 36(20.0%) and the majority who use a condom as preventive majors were 110(61.1%)

4.3 DISCUSSION OF THE FINDINGS

Several studies have argued that young school girls engage in sex with older partners and have transactional sex whereby gifts or money are exchanged for sex. And such relationships result in young women having little or no negotiating power with their partners to insist on condom usage a situation which may result in a high risk of becoming pregnant (Mchunu *et al.*, 2012). Concerning the context of data analyzed in Group scolaire Rwamagana, those who don't use contraceptives were found to be 107(59.4%) while 71(39.4%) do face sexual intercourse which may lead to teenage students to an unplanned pregnancy. Moreover, Access to reproductive health services is another factor that contributes to teenage pregnancy since young people always want to be able to access sexual and reproductive health information and services without being exposed to public stigma (Mchunu, *et al.*, 2012). Annoyingly, with all 180 teenage secondary students, 32(17.8%) do not access easily reproductive health information. Literature showed that different countries had decided to teach teens about reproductive health, to increase their awareness (Kyilleh, Tabong, and Konlaan, 2018). Common reproductive health they often taught include the use of contraceptives as a part of family planning, avoiding peer pressure, prevention of STIs, and knowing the physiological change of their body at teenage age (Kyilleh, Tabong, and Konlaan, 2018). In this manner, teenage participants of the study regarde physical changes of the body as pubic hair growth 130(77.7%) and starting of the menstrual period as 50(22.3%) counting.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter highlights the conclusion, recommendations as well as suggestions for further study. The study delivered the current factors associated with teenage pregnancy among students Group scolaire Rwamagana.

5.1 CONCLUSION

In conclusion, Teenage pregnancies are a global social and health challenge that affects the long life of the teenage young generation. This study revealed the existence of social, economic factors that predispose teenage to unintended pregnancy. In which inadequate social support among young student teenage and lack of inadequate discussions to sexual and reproductive health are prominent and its effects is a problem to the presenting life and future life of the upcoming generation.

5.2 RECOMMENDATIONS

Based on the findings of this study, it is recommended that:

PARENTS: Be responsible for holistic care of teenage young girls, as well as being able to discuss the usual life of sexual and reproductive health. both parents should be to live the real-life sexual patterns not as norms of the culture but for the health's sake of the future and present generation. In every life, either poor or rich parents should be able to teach children to be happy and satisfied with any single step situation of life. But more importantly, parents should try to offer every possible need to the children

G.S Rwamagana Administration: Secondary school administrators should invest in daily educative body physiological change of young girls; provide health education on sexual and reproductive health. The school should cooperate with the parents for the best follow-up of young girls and as well as ensure the consistency of good manners of the children. Finally, the school should cooperate with Health services with all means of pregnancy prevention and all related sexually transmitted diseases.

Ministry of health: The ministry of health should provide the educative guidelines intended to teach on sexual and reproductive health among the young generation. Ensure successful assessment on needs and conflicts elimination among families that may chase young girls to school dropout and facing early sexual intercourse life. It should also support contraceptive methods and teaching among the young generation and as well as the protocol teachings on sexual disease prevention.

5.3 SUGGESTIONS FOR FURTHER STUDY

This study aimed to assess factors associated with teenage pregnancy at G.S Rwamagana; it is prominent that young girls face unintended pregnancy. The study showed the prominence of social and economic factors associated with teenage pregnancy among teenage in secondary.

The other deductive research should invest in specific factors as direct instead of being wide in the research study. And also, the researchers should find out the year-to-year prevalence of teenage pregnancy among the young generation.

REFERENCES

1) Abdelsattar, M. (2016) 'International Journal of Advanced Research in Biological Sciences Teenage Pregnancy in Upper Egypt', *Int. J. Adv. Res. Biol. Sci*, 3(4), pp. 35–41. Available at: www.ijarbs.com.
2) Abebe, F. E. *et al.* (2016) 'Factors leading to cesarean section delivery at Felegehiwot referral hospital, Northwest Ethiopia: A retrospective record review', *Reproductive Health*, 13(1), pp. 1–7. DOI: 10.1186/s12978-015-0114-8.
3) Ahinkorah, B. O. *et al.* (2021) 'Prevalence of first adolescent pregnancy and its associated factors in sub-Saharan Africa: A multi-country analysis', *PLoS ONE*, 16(2 February), pp. 1–16. DOI: 10.1371/journal.pone.0246308.
4) Bull, S. *et al.* (2016) 'Text messaging, teen outreach program, and sexual health behavior: A cluster randomized trial', *American Journal of Public Health*, 106, pp. S117–S124. DOI: 10.2105/AJPH.2016.303363.
5) Cadena-camargo, Y. *et al.* (2020) 'Experiences of pregnancy in the adolescence of internally displaced women in Bogotá : an ethnographic approach', 0, pp. 1–12.
6) CDC, 2017 (2017) 'ADOLESCENT PREGNANCY : A Review of the Evidence ADOLESCENT PREGNANCY : A Review of the Evidence'. Available at: https://www.unfpa.org/adolescent-pregnancy.
7) Farber, N. (2018) *Adolescent Pregnancy: Past, Present and Future Trends and Issues, Adolescent Pregnancy: Past, Present and Future Trends, and Issues*. DOI: 10.3390/books978-3-03842-295-2.
8) Federation, T. I. *et al.* (2010) 'Democratic People's Republic of Korea : Floods', 29(June), pp. 1–7.
9) FHI 360 (2013) 'Mobile for Reproductive Health Project: Tanzania'. Available at: http://www.fhi360.org/sites/default/files/media/documents/m4rh-tanzania-brief.pdf.
10) Franjic, S. (2018) 'Adolescent Pregnancy is a Serious Social Problem', *Journal of Gynecological Research and Obstetrics*, 4, pp. 6–9.
11) Furstenberg, F. F. (2007) 'Destinies of the disadvantaged: The politics of teenage childbearing', *Destinies of the Disadvantaged: The Politics of Teenage Childbearing*,

pp. 1–203. DOI: 10.5860/choice.46-2960.

12) Gayatri, M. (2021) ‘Socioeconomic determinants of adolescent pregnancy in Indonesia: A population-based survey’, *Annals of Tropical Medicine & Public Health*, 24(01). DOI: 10.36295/asro.2021.24186.

13) Glynn, J. R. *et al.* (2018) 'Early school failure predicts teenage pregnancy and marriage : A large population-based cohort study in northern Malawi', 92, pp. 1–17.

14) Habte, A. *et al.* (2022) 'Disparities in sexual and reproductive health services utilization among urban and rural adolescents in southern Ethiopia, 2020: a comparative cross-sectional study, *BMC Public Health*, 22(1), pp. 1–17. DOI: 10.1186/s12889-022-12634-x.

15) JIJUKIRWA, A. (2020) ‘Situational Analysis of Teenage Pregnancy & Teen Mothers in Rwanda Conducted By Ajprodho Jijukirwa in Partnership With’.

16) Kassa, G. M. *et al.* (2018) ‘Prevalence and determinants of adolescent pregnancy in Africa : a systematic review and Meta-analysis’, pp. 1–17.

17) Kyilleh, J. M., Tabong, P. T. N. and Konlaan, B. B. (2018) 'Adolescents' reproductive health knowledge, choices, and factors affecting reproductive health choices: A qualitative study in the West Gonja District in Northern region, Ghana', *BMC International Health and Human Rights*, 18(1), pp. 1–12. DOI: 10.1186/s12914-018-0147-5.

18) Leung, C. (2004) 'Born too soon, *Neuroendocrinology Letters*, 25(SUPPL. 1), pp. 133–136. DOI: 10.2307/3965140.

19) Malaysia, W. B. O. D. on (2018) ‘Api_Sp’, p. 4.

20) Mchunu, G. *et al.* (2012) ‘Adolescent pregnancy and associated factors in South African youth’, *African Health Sciences*, 12(4), pp. 426–434. DOI: 10.4314/ahs.v12i4.5.

21) Neal, S. *et al.* (2020) ‘Trends in adolescent first births in sub-Saharan Africa: A tale of increasing inequity?’, *International Journal for Equity in Health*, 19(1), pp. 1–11. DOI: 10.1186/s12939-020-01251-y.

22) Nkhoma, D. E. *et al.* (2020) ‘Girls’ empowerment and adolescent pregnancy: A systematic review’, *International Journal of Environmental Research and Public Health*, 17(5). DOI: 10.3390/ijerph17051664.

23) Nkurunziza, A. *et al.* (2020) ‘Breaking barriers in the prevention of adolescent pregnancies for in-school children in Kirehe district (Rwanda): A mixed-method study for the development of a peer education program on sexual and reproductive health’,

Reproductive Health, 17(1), pp. 1–8. DOI: 10.1186/s12978-020-00986-9.

24) Norton, M. and Chandra-mouli, V. (2017) 'Interventions for Preventing Unintended, Rapid Repeat Pregnancy Among Adolescents : A Review of the Evidence and Lessons From High-Quality Evaluations', (Table 1), pp. 547–570.

25) Obrowski, M. (2016) 'Normal Pregnancy: A Clinical Review', *Academic Journal of Pediatrics & Neonatology*, 1(1), pp. 15–18. DOI: 10.19080/ajpn.2016.01.555554.

26) Pérez, W. *et al.* (2021) 'Trends and factors related to adolescent pregnancies: an incidence trend and conditional inference trees analysis of northern Nicaragua demographic surveillance data', *BMC Pregnancy and Childbirth*, 21(1), pp. 1–14. DOI: 10.1186/s12884-021-04215-4.

27) Powers, J. A. (2020) 'Introducing an Innovative Strategy for Pregnancy Prevention in Oklahoma City University- Kramer School of Nursing.

28) The report, M. (2009) 'ICPD and the MDGs: Working as One', 15, pp. 1–194.

29) UNFPA (2018) 'Report on the regional forum on adolescent pregnancy, child marriage, and early union in South-Asia and Mongolia', (April), pp. 1–89. Available at: https://www.unicef.org/eap/media/3696/file/Adolescent pregnancy.pdf.

30) UNICEF (2018) 'Situation Analysis of Adolescent Pregnancy in Guyana'.

31) Uwizeye, D., Muhayiteto, R., Kantarama, E. and Wiehler, S. (2020) 'Heliyon Prevalence of teenage pregnancy and the associated contextual correlates in Rwanda', *Heliyon*, 6(April 2019), p. e05037. DOI: 10.1016/j.heliyon.2020.e05037.

32) Uwizeye, D., Muhayiteto, R., Kantarama, E., Wiehler, S., *et al.* (2020) 'Prevalence of teenage pregnancy and the associated contextual correlates in Rwanda', *Heliyon*, 6(10), p. e05037. DOI: 10.1016/j.heliyon.2020.e05037.

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

34) WHO (2014) 'Contraception: Issues in Adolescent Health and Development, *WHO discussion papers on adolescence*, p. 36. Available at: http://apps.who.int/iris/bitstream/10665/42901/1/9241591447_eng.pdf.

35) Winnable, C. D. C. and Final, B. (2015) 'Trends in Teen Pregnancy Winnable Battle Indicator Considerations in Choosing Teen Pregnancy as Winnable Battle Challenges / Obstacles CDC Contributions in Teen Pregnancy Winnable Battle', pp. 2009–2011. Available at: https://www.cdc.gov/winnablebattles/report/teenPregnancy.html.

36) Yasmin, G., Kumar, A. and Parihar, B. (2014a) 'A STUDY OF

SOCIODEMOGRAPHIC FACTORS OF TEENAGE PREGNANCY AT A TERTIARY CARE CENTRE', *Journal of Evolution of Medical and Dental Sciences*, 3, p. 1020+. Available at: https://link.gale.com/apps/doc/A646117899/AONE?u=anon~885ead11&sid=googleScholar&xid=73828204.

37) Yasmin, G., Kumar, A., and Parihar, B. (2014b) 'Teenage Pregnancy - Its Impact on Maternal and Fetal Outcome', *International Journal of Scientific Study*, 1(6), pp. 9–13.
38) Yussif, A. S. *et al.* (2017) 'The long-term effects of adolescent pregnancies in a community in Northern Ghana on subsequent pregnancies and births of the young mothers', *Reproductive Health*, 14(1), pp. 1–7. DOI: 10.1186/s12978-017-0443-x.
39) Zulaika, G. *et al.* (2022) 'Impact of COVID-19 lockdowns on adolescent pregnancy and school dropout among secondary schoolgirls in Kenya', *BMJ Global Health*, 7(1), pp. 1–9. DOI: 10.1136/bmjgh-2021-007666.

40) Abdelsattar, M. (2016) 'International Journal of Advanced Research in Biological Sciences Teenage Pregnancy in Upper Egypt', *Int. J. Adv. Res. Biol. Sci*, 3(4), pp. 35–41. Available at: www.ijarbs.com.
41) Abebe, F. E. *et al.* (2016) 'Factors leading to cesarean section delivery at Felegehiwot referral hospital, Northwest Ethiopia: A retrospective record review', *Reproductive Health*, 13(1), pp. 1–7. doi: 10.1186/s12978-015-0114-8.
42) Ahinkorah, B. O. *et al.* (2021) 'Prevalence of first adolescent pregnancy and its associated factors in sub-Saharan Africa: A multi-country analysis', *PLoS ONE*, 16(2 February), pp. 1–16. doi: 10.1371/journal.pone.0246308.
43) Bull, S. *et al.* (2016) 'Text messaging, teen outreach program, and sexual health behavior: A cluster randomized trial', *American Journal of Public Health*, 106, pp. S117–S124. doi: 10.2105/AJPH.2016.303363.
44) Cadena-camargo, Y. *et al.* (2020) 'Experiences of pregnancy in adolescence of internally displaced women in Bogotá : an ethnographic approach', 0, pp. 1–12.
45) CDC, 2017 (2017) 'ADOLESCENT PREGNANCY : A Review of the Evidence ADOLESCENT PREGNANCY : A Review of the Evidence'. Available at: https://www.unfpa.org/adolescent-pregnancy.
46) Farber, N. (2018) *Adolescent Pregnancy: Past, Present and Future Trends and Issues*, *Adolescent Pregnancy: Past, Present and Future Trends and Issues*. doi:

10.3390/books978-3-03842-295-2.

47) Federation, T. I. *et al.* (2010) 'Democratic People ' s Republic of Korea : Floods', 29(June), pp. 1–7.

48) FHI 360 (2013) 'Mobile for Reproductive Health Project: Tanzania'. Available at: http://www.fhi360.org/sites/default/files/media/documents/m4rh-tanzania-brief.pdf.

49) Franjic, S. (2018) 'Adolescent Pregnancy is a Serious Social Problem', *Journal of Gynecological Research and Obstetrics*, 4, pp. 6–9.

50) Furstenberg, F. F. (2007) 'Destinies of the disadvantaged: The politics of teenage childbearing', *Destinies of the Disadvantaged: The Politics of Teenage Childbearing*, pp. 1–203. doi: 10.5860/choice.46-2960.

51) Gayatri, M. (2021) 'Socioeconomic determinants of adolescent pregnancy in Indonesia: A population-based survey', *Annals of Tropical Medicine & Public Health*, 24(01). doi: 10.36295/asro.2021.24186.

52) Glynn, J. R. *et al.* (2018) 'Early school failure predicts teenage pregnancy and marriage : A large population- based cohort study in northern Malawi', 92, pp. 1–17.

53) Habte, A. *et al.* (2022) 'Disparities in sexual and reproductive health services utilization among urban and rural adolescents in southern Ethiopia, 2020: a comparative cross-sectional study', *BMC Public Health*, 22(1), pp. 1–17. doi: 10.1186/s12889-022-12634-x.

54) JIJUKIRWA, A. (2020) 'Situational Analysis of Teenage Pregnancy & Teen Mothers in Rwanda Conducted By Ajprodho Jijukirwa in Partnership With'.

55) Kassa, G. M. *et al.* (2018) 'Prevalence and determinants of adolescent pregnancy in Africa : a systematic review and Meta-analysis', pp. 1–17.

56) Kyilleh, J. M., Tabong, P. T. N. and Konlaan, B. B. (2018) 'Adolescents' reproductive health knowledge, choices and factors affecting reproductive health choices: A qualitative study in the West Gonja District in Northern region, Ghana', *BMC International Health and Human Rights*, 18(1), pp. 1–12. doi: 10.1186/s12914-018-0147-5.

57) Leung, C. (2004) 'Born too soon', *Neuroendocrinology Letters*, 25(SUPPL. 1), pp. 133–136. doi: 10.2307/3965140.

58) Malaysia, W. B. O. D. on (2018) 'Api_Sp', p. 4.

59) Mchunu, G. *et al.* (2012) 'Adolescent pregnancy and associated factors in South African youth', *African Health Sciences*, 12(4), pp. 426–434. doi: 10.4314/ahs.v12i4.5.

60) Neal, S. *et al.* (2020) 'Trends in adolescent first births in sub-Saharan Africa: A tale of

increasing inequity?', *International Journal for Equity in Health*, 19(1), pp. 1–11. doi: 10.1186/s12939-020-01251-y.

61) Nkhoma, D. E. *et al.* (2020) 'Girls' empowerment and adolescent pregnancy: A systematic review', *International Journal of Environmental Research and Public Health*, 17(5). doi: 10.3390/ijerph17051664.

62) Nkurunziza, A. *et al.* (2020) 'Breaking barriers in the prevention of adolescent pregnancies for in-school children in Kirehe district (Rwanda): A mixed-method study for the development of a peer education program on sexual and reproductive health', *Reproductive Health*, 17(1), pp. 1–8. doi: 10.1186/s12978-020-00986-9.

63) Norton, M. and Chandra-mouli, V. (2017) 'Interventions for Preventing Unintended , Rapid Repeat Pregnancy Among Adolescents : A Review of the Evidence and Lessons From High-Quality Evaluations', (Table 1), pp. 547–570.

64) Obrowski, M. (2016) 'Normal Pregnancy: A Clinical Review', *Academic Journal of Pediatrics & Neonatology*, 1(1), pp. 15–18. doi: 10.19080/ajpn.2016.01.555554.

65) Pérez, W. *et al.* (2021) 'Trends and factors related to adolescent pregnancies: an incidence trend and conditional inference trees analysis of northern Nicaragua demographic surveillance data', *BMC Pregnancy and Childbirth*, 21(1), pp. 1–14. doi: 10.1186/s12884-021-04215-4.

66) Powers, J. A. (2020) 'Introducing an Innovative Strategy for Pregnancy Prevention in Oklahoma City University- Kramer School of Nursing'.

67) Report, M. (2009) 'ICPD and the MDGs: Working as One', 15, pp. 1–194.

68) UNFPA (2018) 'Report on the regional forum on adolescent pregnancy, child marriage and early union in South-Asia and Mongolia', (April), pp. 1–89. Available at: https://www.unicef.org/eap/media/3696/file/Adolescent pregnancy.pdf.

69) UNICEF (2018) 'Situation Analysis of Adolescent Pregnancy in Guyana'.

70) Uwizeye, D., Muhayiteto, R., Kantarama, E. and Wiehler, S. (2020) 'Heliyon Prevalence of teenage pregnancy and the associated contextual correlates in Rwanda', *Heliyon*, 6(April 2019), p. e05037. doi: 10.1016/j.heliyon.2020.e05037.

71) Uwizeye, D., Muhayiteto, R., Kantarama, E., Wiehler, S., *et al.* (2020) 'Prevalence of teenage pregnancy and the associated contextual correlates in Rwanda', *Heliyon*, 6(10), p. e05037. doi: 10.1016/j.heliyon.2020.e05037.

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

73) WHO (2014) ‘Contraception: Issues in Adolescent Health and Development’, *WHO discussion papers on adolescence*, p. 36. Available at: http://apps.who.int/iris/bitstream/10665/42901/1/9241591447_eng.pdf.

74) Winnable, C. D. C. and Final, B. (2015) ‘Trends in Teen Pregnancy Winnable Battle Indicator Considerations in Choosing Teen Pregnancy as Winnable Battle Challenges / Obstacles CDC Contributions in Teen Pregnancy Winnable Battle’, pp. 2009–2011. Available at: https://www.cdc.gov/winnablebattles/report/teenPregnancy.html.

75) Yasmin, G., Kumar, A. and Parihar, B. (2014a) ‘A STUDY OF SOCIODEMOGRAPHIC FACTORS OF TEENAGE PREGNANCY AT A TERTIARY CARE CENTRE’, *Journal of Evolution of Medical and Dental Sciences*, 3, p. 1020+. Available at: https://link.gale.com/apps/doc/A646117899/AONE?u=anon~885ead11&sid=googleScholar&xid=73828204.

76) Yasmin, G., Kumar, A. and Parihar, B. (2014b) ‘Teenage Pregnancy - Its Impact on Maternal and Fetal Outcome’, *International Journal of Scientific Study*, 1(6), pp. 9–13.

77) Yussif, A. S. *et al.* (2017) ‘The long-term effects of adolescent pregnancies in a community in Northern Ghana on subsequent pregnancies and births of the young mothers’, *Reproductive Health*, 14(1), pp. 1–7. doi: 10.1186/s12978-017-0443-x.

78) Zulaika, G. *et al.* (2022) ‘Impact of COVID-19 lockdowns on adolescent pregnancy and school dropout among secondary schoolgirls in Kenya’, *BMJ Global Health*, 7(1), pp. 1–9. doi: 10.1136/bmjgh-2021-007666.

APPENDICES

APPENDIX 1: INFORMED CONSENT

TOPIC: ASSESSMENT OF THE FACTORS ASSOCIATED WITH TEENAGE PREGNANCY AMONG STUDENTS IN G.S RWAMAGANA.

WE Rwabukwere Alice and Mukamparirwa Jeanette, students in level four. Kibogora polytechnic University, department of health sciences, faculty of General nursing, we are conducting a study in this secondary school under the supervision of Jean Paul Nsengiyumva Lecturer in Kibogora polytechnic.

You will not get a direct benefit like the amount of money or any financial interest from this study. The information you provide will be confidential and kept securely, and it will only be used for this study. Your identity will be disclosed in any published and written material resulting from the study, the participation in this study is voluntary and you are free to ask any questions or discuss any change with me.

I have been informed about the study procedure and I agree to participate in this study

Signature of the participant……..Date……./…../2022

Contact: +250781182213, +250785303001

APPENDIX 2: BUDGET OF RESEARCH

This research to be completed needs both human and financial resources. For this research to be conducted well, the Researcher will need financial means to accomplish all activities related to a research project.

PREPARATION OF RESEARCH PROPOSAL AND SUBMISSION

No	Items	People needed	Unity	Unit price/Rwf	Total price/Rwf
1	Internet	2	7	1000	14,000
2	Communication	2	7	500	7000
3	Printout questionnaire	180	6	30	32,400
4	Final printout	2	54	50	5,400
5	Ticket	2	2	5800	23,200
	Total				82,000

APPENDIX 3: RESEARCH QUESTIONNAIRE

This questionnaire is composed of two parts: part 1 which is the individual identification, part 2 is the short questions related to the factors associated with teenage pregnancy. You are requested to respond to every question in part 1 and part 2.

PART 1 INDIVIDUAL IDENTIFICATIONS

Demographic information

1. What is your age?

2. Where do you live

A. Urban B. Rural

3. Indicate your religious/faith

A. Moslem B. Protestant C. Catholic

D. Other/specify…….

4. Have your parents attended formal education?

A. Yes B. No

5. If yes what is their level of education?

A. Primary school B. secondary school

C. University

8. Some girls marry before 15 years; do you think this is good?

A. Yes

B. No

Economic factors associated with teenage pregnancy

9. What is your father's/Guardian's occupational status?

A. Unemployed B. Employed

C. Self employed

10. What is your mother's/Guardian's occupational status?

A. Unemployed B. Employed

C. Self employed

11. Have you ever engaged in sex for money?

A. Yes B. No

12. Do your parents offer adequate support at home and or school?

A. Yes B. No

13. If not married, do get any financial support from your boyfriend/girlfriend?

G

A. Yes B. No

14. Do you depend on that support

A. Yes B. No

15. Does he/she give you much more financial support than your need?

A. Yes B. No

16. Have you ever had more than one partner?

A. Yes B. No

17. If yes to the above was this because of financial reasons?

A. Yes B. No

18. Do you ever need particular needs (money for tea, ticket,…..)

A. Yes B. No

19. If yes how do you get it(Specify,……)

Social factors associated with teenage pregnancy

20. Whom do you live with?

A. Both parents B. Father only

C. Mother only D. Husband

E. Guardian/adoptive parents F. No permanent place

21. Have you had sexual intercourse?

A. Yes B. No

22. What led you to have sexual intercourse?

A. Self-desire B. Curiosity

C. Peer pressure/ D. Pressure of partner

E. To get pregnant

F. Other reasons (please specify…….

Sexual abuse

23. Have you experienced forced sexual intercourse?

A. Yes B. No

24. If yes, how old was your partner?

A. older than you? B. Same age as you?

C. Younger than you?

Alcoholism and drug

25. Do you drink alcohol

A. Yes B. No

26. If yes, who has influenced you?

A. Peers B. Your boyfriend

C. Your parents D. Other specify……

Sexuality and reproductive health knowledge

27. Do you easily access reproductive health information?

A. Yes B. No

28. If the answer is no, what seems to obstacle?

A. Your parents B. Your religion

C. No enough health service

29. How do you get sexual reproductive and health information?

A. From radio B. From television

C. From internet D. From parents

E. From peers F. From religion

G. Other (specify…….

30. What physical changes do girls notice during puberty? (please specify……..

A. Growth of pubic hairs/ B. breasts develop

C. Starting of menstruation D. Other (specify……..)

31. Have you had your menstrual period?

A. Yes B. No

32. If yes, how old were you when you had the first menstrual period?

33. What information did you receive about menstruation?

A. It is painful B. You are ready to have a baby

C. You are ready to get married

D. Avoiding sexual intercourse

E. About hygiene

F. Other (specify…….)

34. When is a girl or woman likely to get pregnant?

A. 14 Days before menstruation

B. 14 after menstruation

C. During menstruation

D. anytime

35. Have you ever had sexual intercourse?

A. Yes B. No

36. If it is yes, at what age was your first sexual intercourse

37. What age of your sexual partner at first sexual intercourse?

38. How many sexual partners do you currently have……..?

39. How many sexual partners have you had?

40. What are the risks/dangers of indulging in sexual intercourse at an early age?

A. Fail at school? B. Become pregnant?

C. Contract STI/HIV/AIDS?

D. Sent out from the family?

41. Do you use any contraceptives?

A. Yes B. No

42. If yes indicate the method you know……?

A. Pills B. Condom

C. Injections D. Other (specify……

43. If not, what are the obstacles to not using it?

A. Parents B. Religion

C. Culture D. Other (specify……

44. Which contraceptive method do you use to prevent both pregnancy and STIs

A. Pills B. Condom

C. Injections D. Other (specify……)

45. Have you/your partner been pregnant before?

A. Yes B. No

46. If yes how old were you at your pregnancy……?

47. Was this a planned pregnancy?

A. Yes B. No

48. At which age a girl is more likely to get pregnant…….?

Family background

49. Did you grow up with both parents?

A. Yes B. No

50. If not, whom did you grow up with…….?

51. Do your parents or Guardian like to discuss with you reproductive health…?

A. Yes B. No