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social justice in health

Teenage Pregnancy and Abortion in Kamuli, Mayuge and Wakiso Districts in Uganda:

A Retrospective Study

FEBRUARY, 2024

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EXECUTIVE SUMMARY

This is a summary of results from retrospective research on teenage pregnancies and abortion conducted in three districts of Kamuli, Mayuge, and Wakiso. The study was conducted between the 4th and 25th August 2023**.**

Introduction:

The study was commissioned by the Center for Health, Human Rights and Development (CEHURD), Uganda with support from Planned Parenthood Global (PPG). CEHURD is an indigenous, non-profit, research and advocacy organization which is pioneering the enforcement of human rights and the justifiability of the right to health in Uganda and the East African Region.

A retrospective study on teenage pregnancies and abortion was conducted in Kamuli, Mayuge and Wakiso districts with the aim of 1) establishing whether and how the prevalence of teenage pregnancies in the three districts was impacted by Covid-19 pandemic and its response; 2) generate and compile data on abortions in the districts and how these are managed; 3) establishing whether there are interventions focusing on re-entry of teenage mothers into schools and 4) making recommendations for improving service provision, policy implementation, advocacy and community action to address problems of teenage pregnancy and unsafe abortion. The study was conducted as an addendum to an ongoing study at Mbarara University of Science and Technology (MUST) titled *'Community-based Alternative Learning Environments for Parenting and Pregnant Teens: A Response to Uganda's Increased Prevalence Due to the Impact of the COVID-19 Global Pandemic'* led by the lead researcher.

Teenage Pregnancy and Abortion in Uganda: Uganda has one of the youngest populations in the world with a median age of 16 years and a high population growth rate of about 3.03%. According to the world population review, the country ranks among the top countries with the highest rates of teenage pregnancy for adolescent girls and young women aged 15 to 19 years. The country continues to register one of the highest rates of teenage pregnancy estimated at 24%, a rate that is close to Sub-Saharan Africa's estimated rate of 24.88%. Unintended teenage pregnancies are the leading causes of high levels of unplanned births, unsafe abortions, and maternal injury and death. Teenage pregnancy remains one of the leading causes of school pregnancy, early marriage and school dropouts. While Article 22(2) of Uganda's Constitution criminalizes abortion unless it is done to save the life of a mother or preserve physical and mental health, it is practiced and remains the leading cause of poor maternal health outcomes including death especially among girls and young women.

The Covid 19 pandemic exposed the lack of strategy and preparedness to provide educational opportunities for girls who become pregnant in the course of their studies to re-enter the school system in Uganda. During the Covid 19 lockdown, younger adolescents (10 to 15 years) became pregnant and have since dropped out of school. Overall, the rate of teen pregnancy in Sub-Saharan Africa is estimated to have increased by 65% causing over one million school dropouts.

Methodology:

In this study, we reviewed records on deliveries and post-abortion care to document the numbers of adolescent girls that were delivered in selected health centres, pre-, during and post-COVID-19 period. We further conducted interviews with health workers to share their experiences of managing adolescent mothers in selected health center IVs in the districts of Kamuli, Mayuge and Wakiso. Lastly, we engaged stakeholders on community and individual barriers to school re-entry after adolescent pregnancy, recognizing that the Ministry of Education and Sports released the 2020 Revised Guidelines for the Prevention and Management of Teenage Pregnancy in School settings in Uganda.

Key findings:

Increase in deliveries among adolescents: The total number of deliveries for all mothers within 6-month periods between 2019 and 2023 was 13,162. Health facilities in Mayuge reported the highest number of deliveries (4,702) followed by Kamuli (4,256) and Wakiso (4,204). Between 2019 and 2023, a total of 3661 births among adolescents and young women between 10 to 20 years were recorded in six-month intervals per year. The total number of deliveries increased between 2019 and 2023. Most of the adolescent deliveries were recorded in the Mayuge district, followed by Kamuli and lastly Wakiso district.

Limited data on post-abortion care: Data on post-abortion care was available only in two facilities assessed in Kamuli and only one facility in Mayuge and 1 in Wakiso. A total of 683 women sought post abortion services at the health facilities visited, 315 were adolescents (13-18), representing 46 percent. Most of these abortions were reported in Wakiso, the second highest was Mayuge district and lastly Kamuli.

Causes of teenage pregnancy: Peer pressure, early initiation of sex, blaming girls for indecent dressing coupled with the effect of trading centres, absence of fathers, lack of sex education and intergenerational effect – *I am a mother because my mother was one*.

« *Some parents dropped out of school while in primary and they got married and produced their children without knowing the value of education. At school a child was punished because of speaking vernacular so the parent came quarrelling because they did not understand that speaking English is important. Most parents just take children to school to learn how to sign and write their names and they feel like that's enough. These same children are the ones who they send them to cut sugarcane, get married and get pregnant early. They feel like education is a waste of time.* » stakeholder 14 Kamuli.

« *Banange, can you imagine teenagers at home doing nothing at home for two years? You can't tell parents to supervise them because parents have to work. We have those trading centres; these days these people have phones where they are on social media and watching pornography. And even the sugar daddies were ready, and they really used our girls. Of course, COVID 19 really affected ehhh...* » health worker 1 Kamuli.

« *These sugarcane boys are becoming a problem. They are between 10 and 18 years and they make some money and confuse our girls. The number shot up during the pandemic and I think that was part of the problem* » health worker 2 Mayuge.

« *Most of these girls think they are too young to get pregnant and so getting pregnant is like an accident* » health worker 1 Kamuli.

« *They don't think you can get pregnant the first time and so some are shocked when they find out they are pregnant and yet they had sex only once* » health worker 3 Mayuge.

Challenges of teenage abortion: pressure to terminate pregnancy; communities are aware that teenagers terminate pregnancy; and the fear and blame that comes with pregnancy. Girls who visit health facilities for post abortion care are discriminated against by health workers.

There was a girl, she said she got pregnant because they gave her a stick and told her if she puts it under the bed, in the middle before having sex, she won't get pregnant and so she was so shocked and could not believe it when she got pregnant Health worker 3 Wakiso.

Peer pressure is a big problem; you find the friends have done it before or know someone who has done it before and so they will encourage their friend to also abort. Remember already they are fearing that their parents will chase them from home and even stop paying school fees, so at that time, it is the best option, and they have their friends to help them. Health worker 1 Mayuge.

Barriers to school return after pregnancy: childcare economic burden on the family, many young girls are forced into marriage to avoid stigma, shame and blame from the community and lack of awareness and strategies on prevention and management of pregnancy in school.

Some parents are relieved because now they don't have to pay school fees anymore because of poverty, it is hard to convince such a parent about taking the girl back to school, but we have convinced a few. A girl who got pregnant and was doing well but got pregnant in S3 and I talked to the mother to get the girl back to school. Plan International school took her up and she is now a teacher. Her mother had been sceptical because she as a widow and the girls' stepfather was not interested in the girl's education, but because we encouraged her. Stakeholder 3 Kamuli

Conclusions and Recommendations

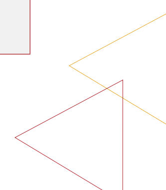
Conclusions: Teenage pregnancy and abortion were on the increase during the COVID-19 pandemic lockdown when schools were closed. Several factors hinder school return after pregnancy and these include childcare, economic burdens on the family, many young girls are forced into marriage to avoid stigma from the community and lack of awareness and strategies on prevention and management of pregnancy in school.

Providing after pregnancy educational opportunities will undoubtedly contribute to pursuit for gender equality in education since their male counterparts are not affected by the same situation.

Denying young girls' chances to complete their education is a form of structural violence perpetrated by family, community, institutions, and policy.

Recommendations: The following are thematic suggestions that form the recommendations proposed during the co-creation meetings held with stakeholders in Kamuli and Wakiso districts on 23rd and 25th August respectively. The recommendations are matched with the action and the actors, they are addressed to prevent and manage teenage pregnancy and its adverse effects on abortion and school dropout. The recommendations and actions are addressed to the roles of different stakeholders: young people, families, communities, government agencies and non-government organizations as actors.

Action	Recommendations	Actors
Promoting collaboration between schools and communities on school re-entry after pregnancy	Schools and communities should ensure that they establish collaborative efforts that promote girls' education after pregnancy	School leaders, local governments, the community politicians and parents
Profiling role models with shared experience on teen pregnancy and school re-entry	Young mothers who have successfully overcome challenges of teen pregnancy should act as role models for school return after pregnancy	Individuals, associations and other interest groups of teen mothers
Nurturing Family Support	Families should offer support to pregnant and parenting adolescents	Parents and other family members, and community leaders
Nurturing community support	Community structures such as places of worship and cultural institutions	Religious and cultural leaders including other society gate keepers
Improving access to sexual and reproductive health information	Ministry of Education and Sports and partners should improve access to information about sexual and reproductive health and reduce risky sexual behaviors attributed to lack of information.	Ministries, departments and partners
Promoting Vocational Skills and self-reliance initiative	Government agencies and NGOs should offer vocational training opportunities for teen mothers	Ministries, departments and partners, Churches and Mosques
Establishing community childcare centres	Local governments and communities should provide childcare centers to support parenting students find time to return to school	Local governments and communities
Promoting participation of fathers/male parenting	Male parents and young men should be involved in the promotion of safe living and learning environment for girls free from sexual violence	Fathers, young men, Community leaders, NGOs
Promoting of Positive Parenting Skills	Build capacity for parents to communicate about growing up and sexual and reproductive health information to their children	Communities, government and non-government organization



Action	Recommendations	Actors
Implementing shelved policies on child protection, sexual and reproductive health and teen pregnancy and girls' education i.e. To address child protection, sexual and reproductive health, teen pregnancy, and girls' education in Uganda, comprehensive policies must be enacted. These include implementing a national strategy for girls' education, integrating comprehensive sexuality education into the curriculum, ensuring youth-friendly health services, prohibiting child marriage with strict enforcement and penalties, empowering youth through skills training, fostering gender-responsive budgeting, engaging communities through awareness programs, holding parents and communities accountable, and implementing a robust monitoring and evaluation framework. Legal reforms should address statutory rape, and a media code of conduct should promote positive gender representations. These policies should be developed collaboratively with stakeholders, regularly reviewed, and adapted to meet evolving needs.	The government and partners should review policy gaps and address factors that fail to implement policies addressed to sexual and reproductive health, child protection and girls' education	Ministries, departments, and partners.
Advocating for acceptance, flexibility, safety, and inclusion in schools	There is a need to promote acceptance, flexibility, safety and inclusion of pregnant teenagers and teenage mothers in the school environment	Ministries and partners, community leaders, parents, head teachers and school owners.

1.0 BACKGROUND

Sustainable Development Goal 5 is the United Nations' global commitment to achieve gender equality and empowerment of women and girls. The target 5.3 is to eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation (UN SDGs). However, teenage pregnancy, child marriage and unsafe abortions continue to hinder progress towards attaining SDG 5 requiring effective and efficient policy response that is evidence based and contextually acceptable to stakeholders (Chandra-Mouli et al., 2019).

Globally during 2021, an estimated 14% of adolescent girls and young women gave birth before age 18, with Sub Saharan Africa countries registering the highest adolescent birth rates (Unicef, 2022). An estimated 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million of them give birth, every year, 55% of the unintended pregnancies end in unsafe abortion abortions (Sully et al., 2020). Developing countries account for 98% of unsafe abortions annually, 41% of which occur among women aged between 15 to 25 years, with the highest ranking in Africa and Latin America, as well, 70% of hospitalizations due to unsafe abortion are among girls below 20 years of age (Barot, 2018; Warriner, 2006).

Uganda has one of the youngest populations in the world with a median age of 16 years and a high population growth rate of about 3.03% (UBOS, 2021). According to the world population review, the country ranks among the top countries with highest rates of teenage pregnancy among girls aged 15 to 19 years (World Population Review, 2023). As per the 2021 UNFPA fact sheet, Uganda registered one of the highest rates of teenage pregnancy estimated rate of 25%, compared to 28% in Sub-Saharan countries and West and Central Africa. Compared to other regions, Central Uganda has a relatively high prevalence of teenage pregnancies, the 2016 Uganda Demographic and Health Survey (UDHS) and the 2018 Uganda Bureau of Statistics (UBOS) Statistical Abstract, Central Uganda registered a teenage pregnancy rate of 31% (Atuhaire, 2019).

Teenage pregnancy is the leading cause of high levels of unplanned births, unsafe abortions, and maternal injury and death that the country experiences (Summers, 2013). While article 22 of Uganda's Constitution criminalizes abortion unless it is done to save the life of a mother or preserve physical and mental health, it is practiced and remains the leading cause of poor maternal health outcomes including death especially among young women and girls (Larsson et al., 2015). Adolescent pregnancy poses a wide range of social and economic burdens at individual and societal levels. For example, a recent report by UNFPA and Uganda's National Planning Authority on the economic and social burdens of teen pregnancy in Uganda estimated that USD 362 million were spent on the reproductive health care of teenage mothers in 2020. That is equivalent to 43 per cent of the Ministry of Health's annual budget. The report estimates that about 64 per cent of teen mothers will not complete primary education, and 60 per cent will end up in peasant agricultural work (NPA, 2021; Unicef, 2021).

Teenage pregnancy does not only pose poor maternal and unsafe abortion, being a teen mother outside marriage causes isolation, failure to continue with school, and is a risk for intergenerational poverty

(Nabugoomu, 2019; Ninsiima et al., 2018). Parenting adolescents are vulnerable to sexual violence and exploitation, social stigma and discrimination, early marriage, unsafe abortions, and even maternal mortality (Nyakato, Kemigisha, Tuhumwire, & Fisher, 2021). "Additionally, adolescent pregnancy often brings an end to educational opportunities for most young girls (Nyariro, 2021). It is rare that these girls will ever go back to school, returning to school for these girls has been found to be successful with support of parents and family (New Vision, 2022; Nyakato, Kemigisha, Mugabi, Nyariro & Kools, 2022).

It is estimated that during COVID 19, around 15 million children in Uganda were unable to attend school for almost two years, of these 30% were estimated to drop out of school due to a number of reasons with unplanned pregnancy and forced marriage being the major factor. According to a study by the Forum for African Women Educationists (FAWE) that assessed the impact of Covid 19 on school going girls and young women in Uganda, there is an estimated increase in teenage pregnancy among very young adolescents (10 to 14 years) of over 360% and in age groups 15 to 19 years and 20 to 24 years the increase was 25.5% and 21.1% respectively (FAWE, 2021; Unicef, 2021). The leading causes of teenage pregnancy were found to include lack of proper parental care, lack of sex education, peer pressure, low education level, and poverty, which leads to early marriage.

While by 2020 only three countries in sub-Saharan Africa had policies that completely bared girls from returning to school after pregnancy, almost no country has successfully registered successful implementation of school return policies after pregnancy (Salvi, 2019). Learning environment is often unsupportive, and policies do not adequately address the real challenges faced by these young people (Coast et al., 2021). Regarding school return after pregnancy and school dropout, a number of factors impede successful implementation of policies and guidelines and these include among others fear that when these girls return to school, they will not be good examples to others, the school environment is tensed with these girls being stigmatized and shamed for sexual misbehavior and immorality (Chambers & Erausquin, 2015; Chiyota & Marishane, 2020). At community and family level, girls suspected to be engaged in sexual relationships or pregnancy are forced in marriage to avoid shame. Traditionally pregnancy before marriage was severely punished and, in some cultures, girls were excommunicated and sometimes killed, this is done to avoid the social repercussions, such as a decreased chance of negotiating a suitable bride-price as an economic benefit and to cope with community shame (Neema et al., 2021; Ninsiima et al., 2018).

The persistence of unplanned pregnancies in most communities is attributed to various factors such as poverty, limited access to reproductive health services, inadequate knowledge of sexual and reproductive health, cultural and social norms, and gender inequalities (Kemigisha, Ivanova, et al., 2019). Teenage pregnancy and unsafe abortion have detrimental effects on the health and overall wellbeing of adolescents, their families, and the community. These repercussions comprise increased maternal morbidity and mortality rates, higher instances of school dropout, poverty, and social exclusion (Nyakato, 2019; Nyakato et al., 2021). Adolescents who face teenage pregnancies and abortions are more inclined to drop out of school and have limited opportunities for economic empowerment. Additionally, adolescent mothers are at a greater risk of experiencing maternal complications such as obstructed labor, postpartum hemorrhage, and sepsis (Kemigisha, Ivanova, et al., 2019)

The lack of sexuality education in Uganda contributes significantly to negative sexual and reproductive health outcomes like teenage pregnancies and unsafe abortions. In a study on the sexual health of very young adolescents, it was found that adolescents had a limited understanding of comprehensive SRH knowledge (Kemigisha et al., 2018). Although media was still a significant source of information for this age group, some adolescents admitted to accessing sexual content that was deemed unsuitable (Kemigisha, Bruce, et al., 2019). Furthermore, a considerable number of sexually active adolescents acknowledged engaging in risky sexual behavior (Kemigisha, Ivanova, et al., 2019; Kemigisha et al., 2018).

A study by Nyakato and others that was conducted in south western Uganda established five obstacles faced by teenage girls who become pregnant and are unable to return to school. These obstacles are: 1) negative self-perception due to being criticized, insulted, and humiliated; 2) economic difficulties caused by being a single mother; 3) anxiety in the school environment as there is fear that the pregnant teens may negatively affect the other girls; 4) tensions within families and communities as mothers are blamed for their daughters' pregnancies; and 5) ineffective re-entry policies without any implementation plan (Nyakato et al., 2022).

The study findings formed a basis for policy recommendations that highlight the importance of involving communities in protecting girls and confronting societal attitudes and cultural beliefs that enable sexual and gender-based violence against them. These recommendations acknowledge the Ministry of Education and Sports' guidelines on granting "second chance" education to pregnant and parenting girls (Nyakato et al., 2021). Nonetheless, there is a growing opposition based on moral, cultural, and religious justifications and promotion of abstinence only strategies for prevention of teenage pregnancy (Kohler, Manhart, & Lafferty, 2008; New Vision, 2022). Religious foundations contribute significantly to Uganda's education sector, according to a report by the Education Policy and Data Center, approximately 65% of primary schools and 57% of secondary schools in Uganda are privately owned, with religious organizations owning a significant portion of those schools (Education Policy and Data Center, 2015).

1.1 Problem Statement – the Relevance after Pregnancy School Return and Girls Education Policy Frameworks and Guidelines

In the case of Uganda, several policies and programs have been designed and implemented in line with management and prevention teenage pregnancy, child marriage and unsafe abortions and as well promote girls' access to education, however, most of these policies are shelved. In this study, we highlight the relevance of policies and programs with potentiality to address prevention and management of teen pregnancy, access to sexual and reproductive health education, education after teen pregnancy and protecting children against sexual and gender-based violence.

As part of the response to the effects of Covid 19 on the escalation of teenage pregnancy among school going children, the Ministry of Education and Sports provided Revised guidelines for the prevention and management of teenage pregnancy in school settings in Uganda (2020) whose overall purpose is to offer guidelines that support prevention and management of teenage pregnancy in school settings, as well as enable girls to return to school after a teen pregnancy. The guidelines referred to the Draft National School Health Policy and National Sexuality Education Framework.

In 2018 the Ministry of Education and Sports (MoES) launched the National Sexuality Education Framework that was developed following wide consultations with a cross-section of stakeholders. While the framework seeks to create an over-arching national direction for providing young people with sexuality education in the formal education setting, it was shelved on religious grounds due to concerns including the use of the term "sexuality" and inclusion of ages 3 – 5 among those to be provided with sexuality education and information.

The Accelerated Education Program designed for disadvantaged over age-out of school children and youth who missed out or were interrupted by poverty, marginalization, conflict and crisis is a strategy for the 2008 Education Act on equal access and has been rolled out successfully by non-government agencies working with refugees but not for other target groups in the general population.

The Children Act 2016 as amended (Cap 59, Laws of Uganda) enhances the protection of children from all forms of violence, outlawed Corporal punishment of children in institutional setting, which introduces

protection of Children from harmful customary practices (e.g., child marriage, FGM/C) as well as penalties for offenders.

Teenage pregnancy and abortion remain a complicated matter with multidimensional negative implications that affect not only young girls and women but the whole society. The social, economic and health complications associated with teen pregnancy manifest in the failure to implement relevant policies, programs and strategies meant to prevent and protect violence against children. Uganda, like most countries in the region have a set of laws and policies that remain on shelf rendering promotion of girls' education and gender equality stalemates. As such, there is need for continued generation of evidence that improves understanding of challenges faced by policy and program implementation.

This study which was commissioned by the Center for Health, Human Rights and Development (CEHURD) aimed at conducting retrospective research on teenage pregnancies and abortion in three Districts (Kamuli, Mayuge and Wakiso). The study was conducted as part of an ongoing research on: *Community-based Alternative Learning Environments for Parenting and Pregnant Teens: A Response to Uganda's Increased Prevalence Due to the Impact of the COVID-19 Global Pandemic.* This part of the study was reviewed and approved by MUST ref. 2022416 and National Council of Science and Technology (UNCST) ref. ss148788), respectively through an addendum.

In this study, records on deliveries and post abortion care were reviewed to document the number of adolescents that delivered in the health centers' pre, during and post Covid 19 period and interview health workers to share their experiences of managing adolescent mothers in selected health center IVs in the target districts. We engaged stakeholders on community and individual barriers to school re-entry after adolescent pregnancy.

1.2 Aims and Objectives

The following are the specific objectives:

1. To establish whether and how the prevalence of teenage pregnancies in the three districts was impacted by Covid-19 pandemic and its response.
2. To generate and compile data on abortions in the districts and how these are managed.
3. To establish whether there are interventions focusing on re-entry of teenage mothers into schools.
4. To generate recommendations for improving service provision, policy implementation, advocacy and community action to address problems of teenage pregnancy and unsafe abortion.

2.0 METHODOLOGY

2.1 Study area

The study was conducted in three districts of Mayuge, Kamuli and Wakiso. Wakiso district is in the central region of Uganda, and it is one of the most urbanized districts in the country because of its proximity to Kampala City. The district exhibits a mix of urban and peri-urban areas, it also has rural parts. The district benefits from its accessibility to the national capital, offering various economic opportunities.

Wakiso district is the most populous district in Uganda with 3.5 million people. Both Mayuge and Kamuli districts are located in the eastern part of the country. The two districts are mainly rural with agriculture as the predominant economic activity for most people. Both districts are ranked among the 20 most populous districts in the country with over 600,000 people per district. The social economic variations play a crucial role in the research study's understanding of teenage pregnancy and abortion prevalence across the district and the potential effects of COVID-19 pandemic.

2.2 Study Design

To comprehensively address the complexity of the phenomena, the study adopted a mixed-methods Community-Based Participatory Research (CBPR) design, integrating both quantitative and qualitative data collection methods. The study conducted a retrospective review of lower health facility records on postnatal and post abortion care record to determine the prevalence and patterns of teenage pregnancies and abortion in the target districts. Since abortion is restricted in the country, post abortion care records were used to provide proxy data on abortion. Qualitative interviews were conducted with health workers and stakeholders. Meetings were organised to co-create recommendations and actions formed by the data collected on the topic. Field work was conducted between 4th and 25th August 2023.

2.3 Data collection Methods

A structured survey questionnaire was designed for assessment of health facilities and collect data on the deliveries/postnatal care and post abortion care records. Eight (08) health facilities were enrolled in the study: 03 in Wakiso, 02 in Kamuli and 03 Mayuge District. Two (02) health facilities (01 in Wakiso and the other in Mayuge) were not included because of lack of records. Nine (09) individual interviews were conducted with 03 health facilities that were selected for the adolescent postnatal and post abortion care records review. Two (02) stakeholders' engagement sessions were organized to co-create recommendations and actions and these were held in Kamuli and Wakiso on 23rd and 25th August respectively.

Table 1: Data collection methods per objective

Objective	Data collection methods	Participants	Area
Objective 1: To Establish whether and how the prevalence of teenage pregnancies in the three districts was impacted by Covid-19 pandemic and its response	Structured questionnaire Individual interviews	Postnatal and post abortion care records provided by Health workers – midwives and records assistants. 09 in charges were interviewed	**Wakiso (**Kajjansi Health Centre IV, Wakiso Health Centre IV and Katabi Health Centre III**)** **Kamuli (**Nankandhulo Health Centre IV and Namwendwa Health Centre IV) **Mayuge** (Kityelela Health Centre IV, Kigandolo Health Centre IV and Mayuge Health Centre IV)
Objective 2: Generate and compile data on abortions in the districts and how these are managed	Individual interviews	09 in charges were interviewed. Postnatal and post abortion care records provided by Health workers – midwives and records assistants.	As above
Objective 3: Establish whether there are interventions focusing on re-entry of teenage mothers into schools	Stakeholder engagement – co-creation meeting	Police, senior men and women, head teachers, community development officer, NGO, Local Government, Religious leaders	Sessions held in Kamuli and Wakiso
Objective 4: Make recommendations for improving service provision, policy implementation, advocacy and community action to address problems of teenage pregnancy and unsafe abortion.	Stakeholder engagement – co-creation meeting	As above	As above

2.3.1 Stakeholder Engagement /Co-creation Sessions

Two (02) stakeholder engagement sessions were held to reflect on the study and propose recommendations and action. The sessions were started with a presentation of the emerging insights from the study and participants were then engaged in a discussion on girls' education after pregnancy. The following questions guided the co-creation sessions:

During 2020, the Ministry of Education and Sports provided revised guidelines to facilitate school re-entry, based on this fact and the results of the study, the stakeholders discussed action steps and recommendations guided by the following questions:

a. Are the guidelines being implemented? If yes how? If no what are the barriers?

b. Should girls be given a second chance to return to school after pregnancy? Why and how?

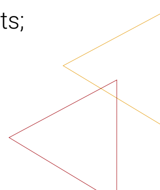
c. What support systems can be implemented within schools and communities for pregnant teenagers to improve access to education after teen pregnancy?

Table 2: Participants for the Stakeholder Engagement /Co-creation Sessions

Category of participants	Number	Representation/Position
Police	1	Assistant Superintendent of Police–Family and Child Protection Unit
Schools	2	Senior Women (1 Primary and 1 Secondary School)
	4	Senior Men (2 Primary and 2 Secondary School)
	4	Head Teachers (2 Primary and 2 Secondary School)
Non-Government Organizations	1	Mental Health NGO from Entebbe
Parents and Guardians	8	Parents of adolescents (05 Fathers and 03 Mothers)
Religious leaders	3	Representatives from the Muslims, Anglican and Pentecostal
Community Opinion Leaders	1	Leader of Acholi Community in Entebbe
District Politicians	2	District counsellors
	2	01 District Vice Chairperson and 02 Deputy Mayors
Local Government	1	District Public Health Officer
	3	Community Development Officers
	1	District Education Officer
	1	District Health Officer A representative from the Senior House Officer office

2.4 Data Management and Analysis

Data was collected by trained research assistants based at health facilities using a structured questionnaire. This included sections such as socio demographics characteristics of respondents;



characteristics of health facilities - including location, services offered and population coverage.

Record review was done for data on pregnancies at 6-months interval between 2019 and 2023, for all mothers and adolescents.

2.4.1 Quantitative Data analysis

All records received were reviewed by the Principal Investigator and two (2) researchers for accuracy. Any missing information and clarifications were sought, and data cleaned accordingly. A google form for data extraction was developed and data subsequently exported to excel. Data analysis was conducted in Stata version 15. Descriptive analyses were made to present proportions, frequencies and comparison of key outcomes per district. Excel was used for creation of the necessary graphs, charts and pie charts to illustrate findings.

2.4.2. Qualitative Data Analysis

Qualitative data generated from interviews with health workers and stakeholder engagement meetings was transcribed and transcripts were then uploaded in NVivo 12 to generate a code book. Codes, code strings and themes were generated through repeated reading of the transcripts and the analysis followed the six stages of thematic analysis suggested by Braun and Clarke. The transcripts were read and reread by the study team members to gain deeper understanding of the meanings of the data to the point of saturation. This allowed us to examine the experiences of being a young mother in relation with opportunities for school return after pregnancy. Initial coding of the transcripts was conducted to study fragments of data including words, lines and segments to understand their meaning. This was followed by focused coding where the initial codes were clustered into the *a priori* domains of change of this evaluation. Emerging themes were also indicated in the analysis. The results are presented in line with the emergent and *a priori* thematic areas (Clarke, Braun, & Hayfield, 2015).

2.5 Limitations of the Study

Data collection for the study was conducted in three districts of Kamuli, Mayuge and Wakiso between 4th and 25th August 2023. The quantitative findings on teenage pregnancy and abortion are based on health facility records on postnatal and post-abortion care collected at an interval of 6 months across 3 years–October 2019 to March 2020; January to June 2021; January to June 2022; and January to June 2023. The study did not assess threatened abortion. The qualitative data was collected using individual interviews with health workers and stakeholder meetings organised inform of workshops.

2.6 Ethical considerations

The study was conducted as an addendum for ongoing research titled *'Community-based Alternative Learning Environments for Parenting and Pregnant Teens: A Response to Uganda's Increased Prevalence Due to the Impact of the COVID-19 Global Pandemic'*. The request for extension and addendum was reviewed and approved by MUST ref. 2022416 and National Council of Science and Technology (UNCST) ref. ss148788), respectively.

The research team is experienced with communities and has conducted similar community-engaged studies (Nyakato et al., 2022); as such, the study processes took into consideration the key principals of human subject's research specifically confidentiality, informed consent, and voluntary participation.

3.0 RESULTS

This section presents research findings for the study conducted between 4th and 25th August 2023, on retrospective assessment of the prevalence of teen pregnancy and abortion in the districts of Kamuli, Mayuge and Wakiso. The study is an addendum for a bigger study which was conducted between May and July 2023 in 3 districts (Mbarara, Isingiro and Rwampara) in south-western Uganda. The bigger study is titled *'Community-based Alternative Learning Environments for Parenting and Pregnant Teens: A Response to Uganda's Increased Prevalence Due to the Impact of the COVID-19 Global Pandemic'*.

The presentation of quantitative findings takes precedence for all the defined objectives, followed by the subsequent presentation of qualitative findings aligned with these objectives. This dual approach serves to encompass both empirical data and community narratives, offering a comprehensive exploration of teenage pregnancies, abortions, and post-pregnancy school reintegration from diverse perspectives.

The results sections is arranged per objective, the first section presents data and findings on the prevalence of teen age pregnancy and abortion derived from selected health facility records on postnatal and post abortion care for adolescents i.e. all deliveries and post abortion care offered to adolescents within a set period of six months across three years i.e. October 2019 to March 2020; January to June 2021; January to July 2022; and January to June 2023. This period caters for a time period for pre, during and post covid 19, when schools in Uganda were closed for about 18 months to prevent the spread of Covid 19.

3.1 Health Facility Records on Adolescent Mothers' Postnatal and Post Abortion Care

Records on teenage pregnancy and abortion were generated from postnatal and post abortion care records in selected health facilities in the three study districts. The records were provided by midwives and records assistants because of their direct responsibility with the study focus, 3 of these were male and 3 females. By training, 4 of the respondents had a diploma and two had certificates, these were mostly health workers.

We reviewed postnatal and post abortion care records in 6 facilities across 3 years at 6 months interval i.e., October 2019 to March 2020; January to June 2021; January to July 2022; and January to June 2023., 2 per district; in Kamuli district it was Nakandhulo HCIV "Kamuli 1" and Namwendwa HC IV "Kamuli 2", in Mayuge district, data was collected in Mayuge HC IV 'Mayuge 1" and Kityelela HC IV "Mayuge 2". Lastly, in Wakiso district, we collected data from Katabi HCIII" Wakiso 1" and Kajjansi HC IV "Wakiso 2". All the facilities apart from one offered basic maternal and child health services including antenatal, postnatal, deliveries, post abortion care and child immunization. Only Katabi HCIII did not offer post abortion care services. The main source of electricity supply was hydroelectricity, although most health facilities had solar as well as a generator.

Table 3: Health Facility Population Coverage

Health facility	District	Level	Population coverage
Nakandulo	Kamuli	IV	40200
Namwendwa	Kamuli	IV	4000
Mayuge	Mayuge	IV	25129
Kityelela	Mayuge	IV	32611
Kajjansi	Wakiso	IV	115500
Katabi	Wakiso	III	29400

3.1.1 Postnatal care/Deliveries for all mothers per District

We assessed total number of deliveries for all mothers in the three districts for the period of October 2019 to June 2023 in a six-month interval.

Table 4: Total deliveries of all mothers per health facility within six-months period interval from 2019 to 2023.

In the following table is a record on deliveries in six-month intervals at 6 health facilities between 2019 and 2023.

Health Facility	Oct 2019 -Mar 2020	Jan – Jun 2021	Jan–Jun 2022	Jan–Jun 2023	Total	Total per district
Kamuli 1	215	540	566	457	1778	4256
Kamuli 2	646	312	915	605	2478	
Mayuge 1	818	876	857	1206	3757	4702
Mayuge 2	192	247	193	313	945	
Wakiso 1	141	566	505	259	1471	4204
Wakiso 2	336	743	728	926	2733	
Total	2348	3284	3764	3766	13162	

The total number of deliveries for all mothers within 6-month periods between 2019 and 2023 was 13,162. Health facilities in Mayuge reported the highest number of deliveries (4702) followed by Kamuli and Wakiso. The total deliveries increased in most health facilities between 2019 and 2022, with a slight decline in 2023 except for Mayuge (Table 4 and Figure 1).

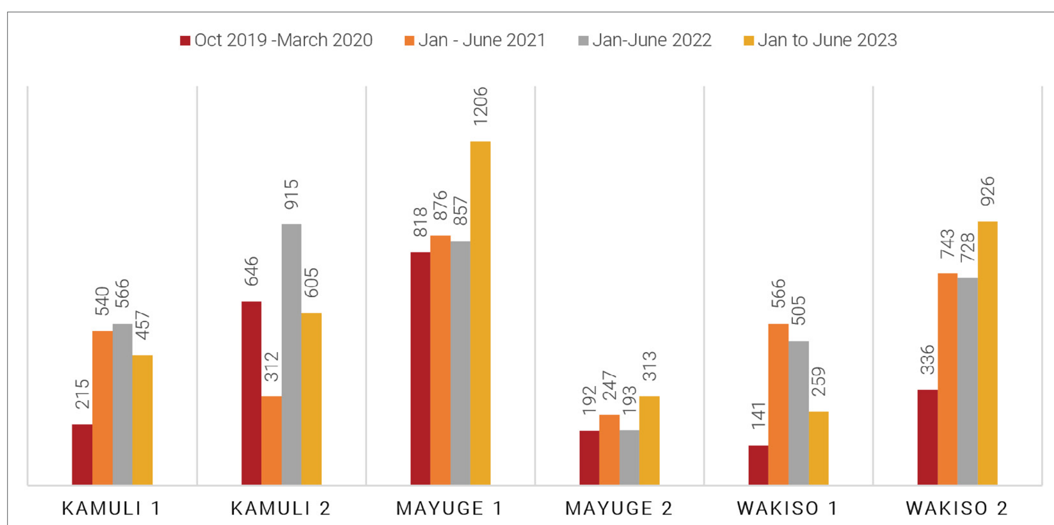


Figure 1: Bar chart for total deliveries in the 6 facilities in 3 districts

3.1.2 Deliveries among adolescent mothers in the three districts between 2019 and 2023

Table 5: Adolescent deliveries in 6 months' intervals between 2019 and 2023

Health Facility	Oct 2019 -Mar 2020	Jan–June 2021	Jan-June 2022	Jan to June 2023	Total
Kamuli 1	84	131	155	164	534
Kamuli 2	259	107	272	171	809
Mayuge 1	233	183	201	286	903
Mayuge 2	189	247	201	313	950
Wakiso 1	9	70	55	22	156
Wakiso 2	45	87	88	89	309
Total	819	825	972	1045	**3661**

Between October 2019 and June 2023, a total of 3661 births among adolescents and young women between 10 to 20 years were recorded in six-month intervals per year. The total number of deliveries increased between October 2019 and June 2023. Most of the adolescent deliveries were recorded in Mayuge district, followed by Kamuli and lastly Wakiso district (Table 5 and 6, Figure 2 and Figure 3).

Table 6: Total adolescent deliveries per district

Period	Kamuli	Mayuge	Wakiso	Total
Oct 2019- Mar 2020	343	422	54	819
Jan to Jun 2021	238	430	157	825
Jan to Jun 2022	427	402	143	972
Jan to June 2023	335	599	111	1045
Total	1343	1853	465	**3661**

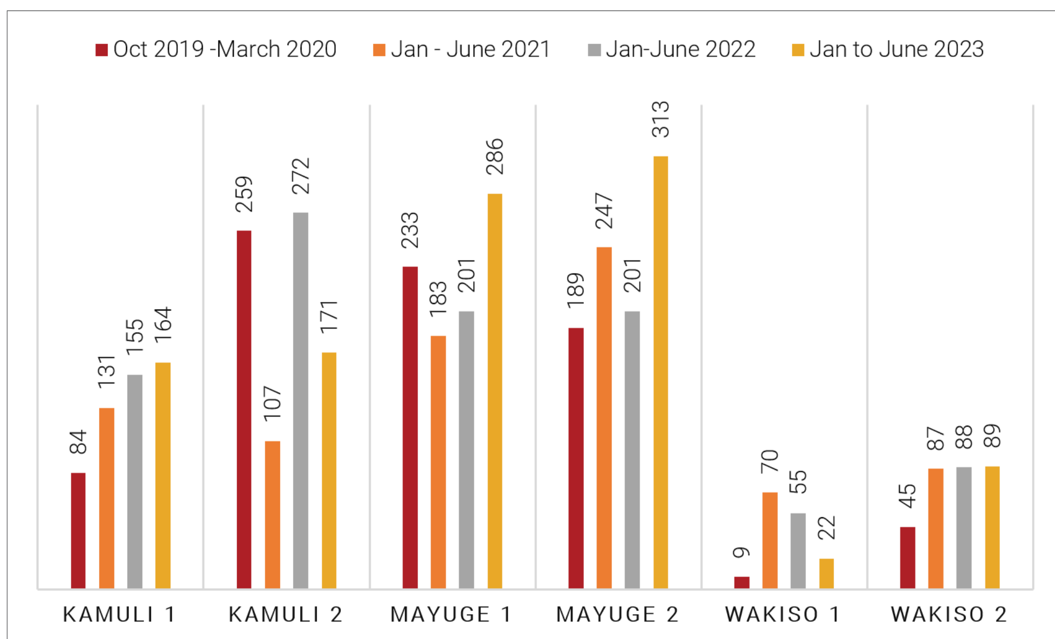


Figure 2: Bar graph showing adolescent deliveries per health facility in 6 months' intervals between 2019 and 2023.

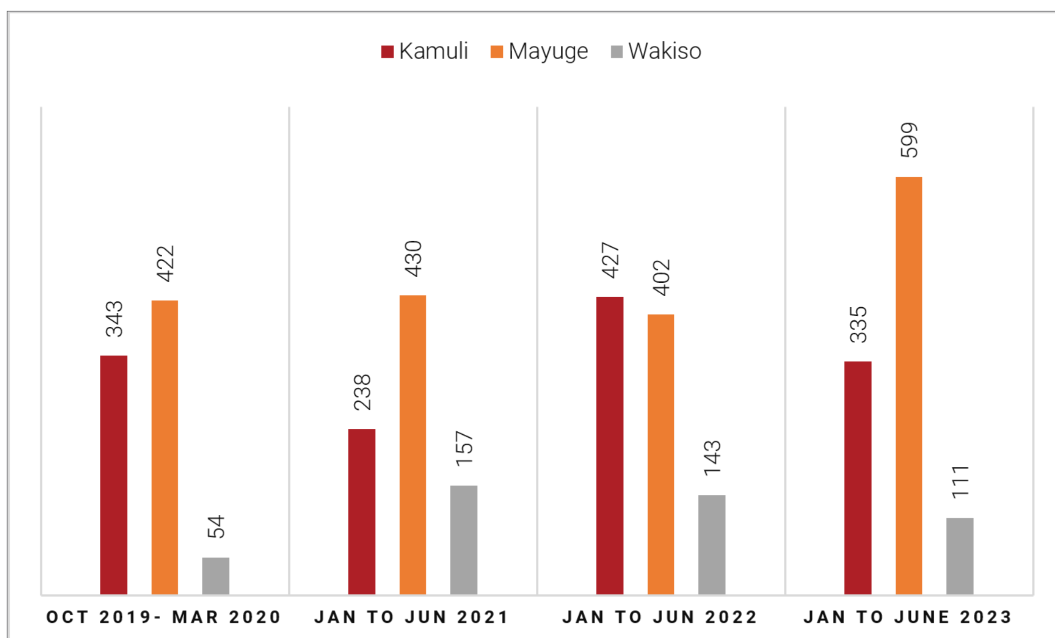


Figure 3: Bar graph showing adolescent deliveries per district in 6 months' intervals between October 2019 and June 2023.

Mayuge District had the highest number of adolescent deliveries, and the pick period was January to June 2023.

3.1.3 Proportions of adolescent births of the total births of all mothers per district

Out of all deliveries recorded in all health facilities (13,162 deliveries), in the six-month intervals between October 2019 and June 2023, 3661 were adolescent mothers. Adolescent births contributed to a total of 27.8 % of all births in the districts. The proportions of adolescent births were highest in Mayuge (38.3 to 41.8%) and lowest in Wakiso (9.4 to 11.3%). (Figure 4 and 5).

Figure 4: A pie chart showing proportion of adolescents and older mothers who delivered in the health facilities in the period of October 2019 and June 2023

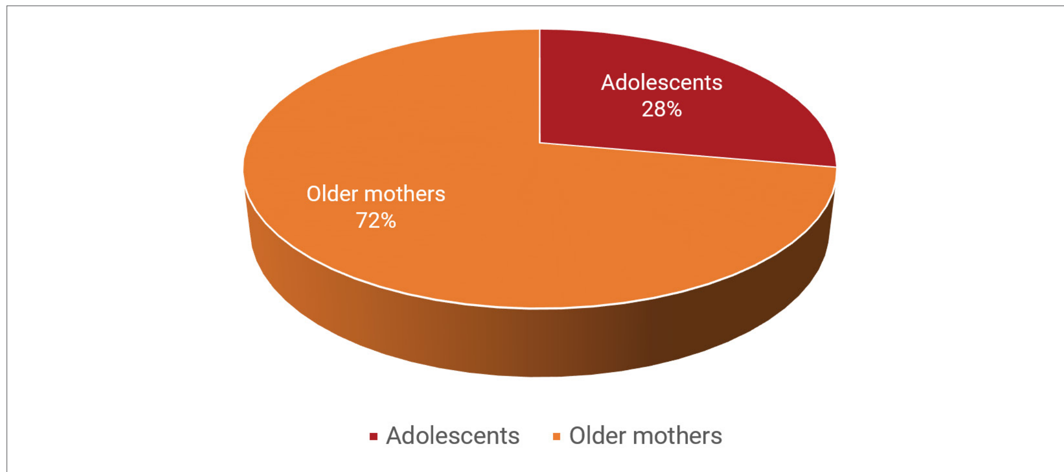
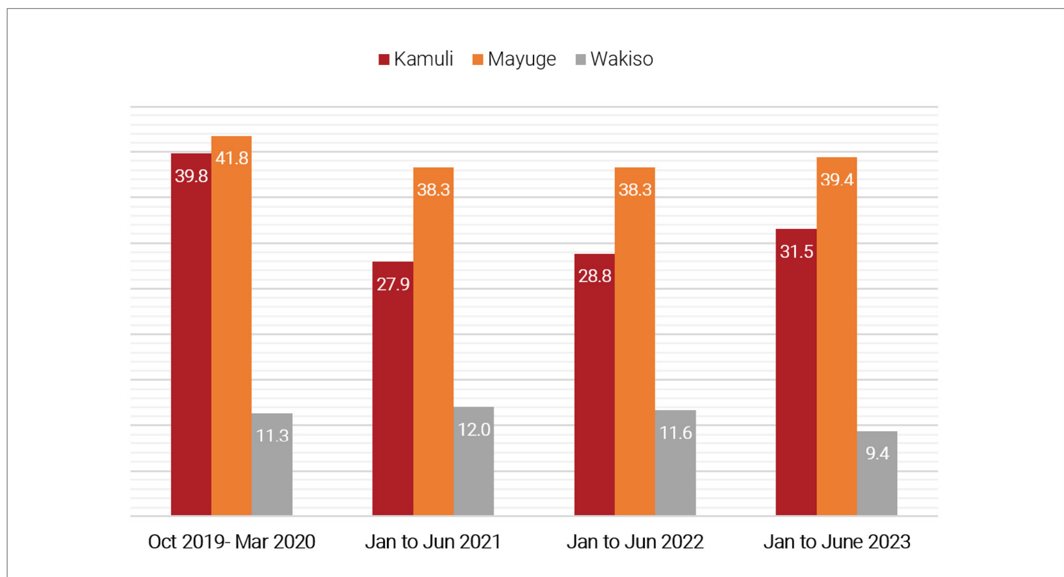


Figure 5: A Bar chart showing proportion of adolescent births per district in the period of October 2019 and June 2023



3.2 Post Abortion Care

To generate evidence on abortion, records on post abortion care were reviewed.

3.2.1 Post abortion care provided to mothers at 6-month assessment periods in 3 districts

This data was available only in two facilities assessed in Kamuli and only one facility in Mayuge and one in Wakiso. For a better comparison of districts, we considered the two facilities in Kamuli as one and estimated an average number of abortions in the district per assessment period (Table 7).

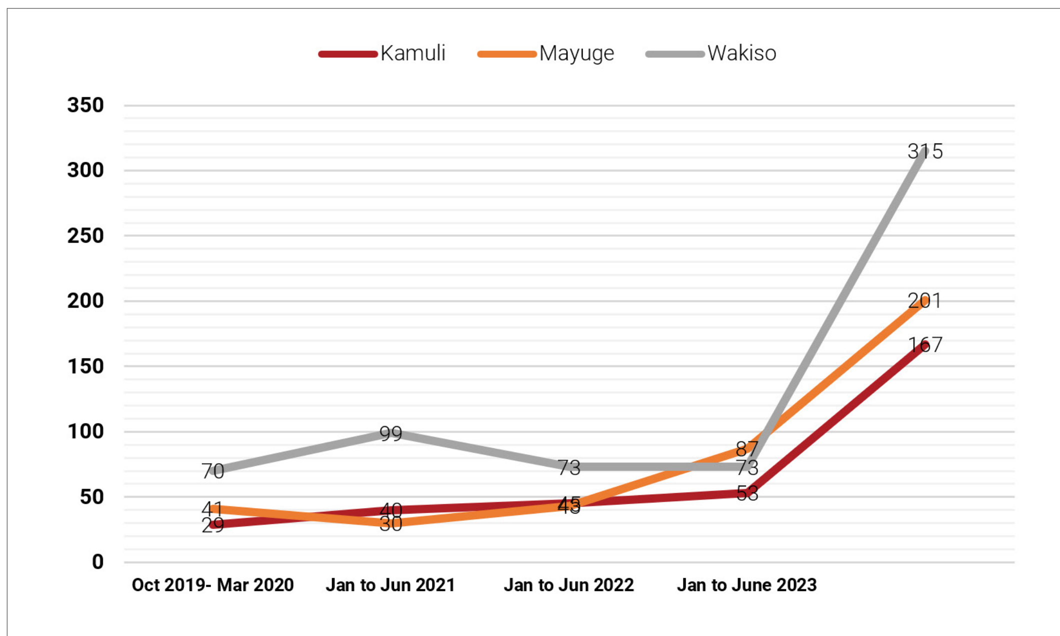
Table 7: Total number of mothers who received PAC between October 2019 and June 2023

Period	Kamuli	Mayuge	Wakiso	Total
October 2019 to March 2020	29	41	70	140
January to June 2021	40	30	99	169
January to June 2022	45	43	73	161
January to June 2023	53	87	73	213
	167	201	315	683

In the assessment period between October 2019 and June 2023, a total of 683 women sought post abortion services at the health facilities visited. Most of these abortions were reported in Wakiso (315 or 46%). The second highest was Mayuge district and lastly Kamuli.

Figure 6: Showing trends in total cases of post abortion care in the three districts.

3.2.2 Post abortion care provided to mothers at 6-month assessment periods in 3 districts.

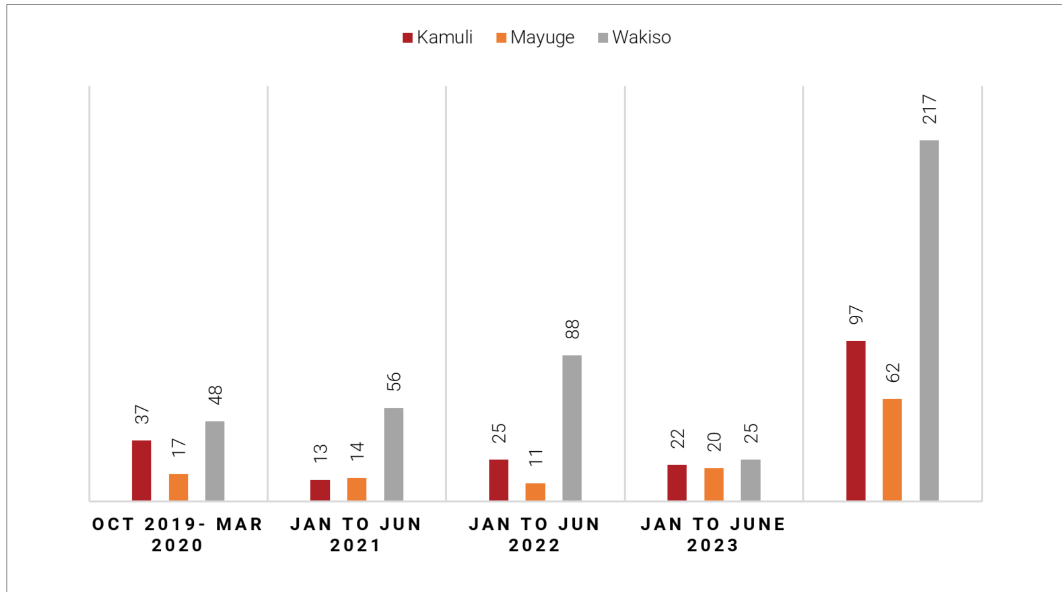


Records for adolescents who received post abortion care (PAC) was available in 4 of 6 facilities assessed. One of the facilities was a health center III and they reportedly did not offer PAC. A total of 513 abortions were reported in the four health facilities among adolescents. For better comparison, we considered the average abortions per district. As such, Wakiso reported highest numbers of adolescents who received PAC, followed by Kamuli and lastly Mayuge (Table 8 and Figure 7).

Table 8: Adolescents per district who received post abortion care between October 2019 and June 2023

Period	Kamuli	Mayuge	Wakiso	Total
Oct 2019- Mar 2020	37	17	48	101
Jan to Jun 2021	13	14	56	83
Jan to Jun 2022	25	11	88	124
Jan to June 2023	22	20	25	67
	97	62	217	375

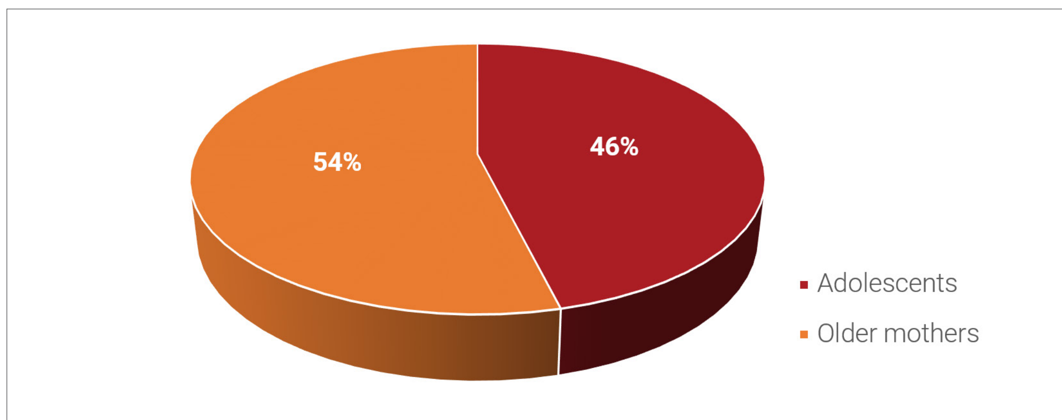
Figure 7: Adolescents per district who received post abortion care between 2019 and 2023.



3.2.3 Proportion of adolescents who receive PAC compared to total mothers.

A total of 315 adolescents received post abortion care out of 683 mothers who received PAC. This represents 46 percent.

Figure 8: Proportion of adolescents compared to older mothers who received PAC.



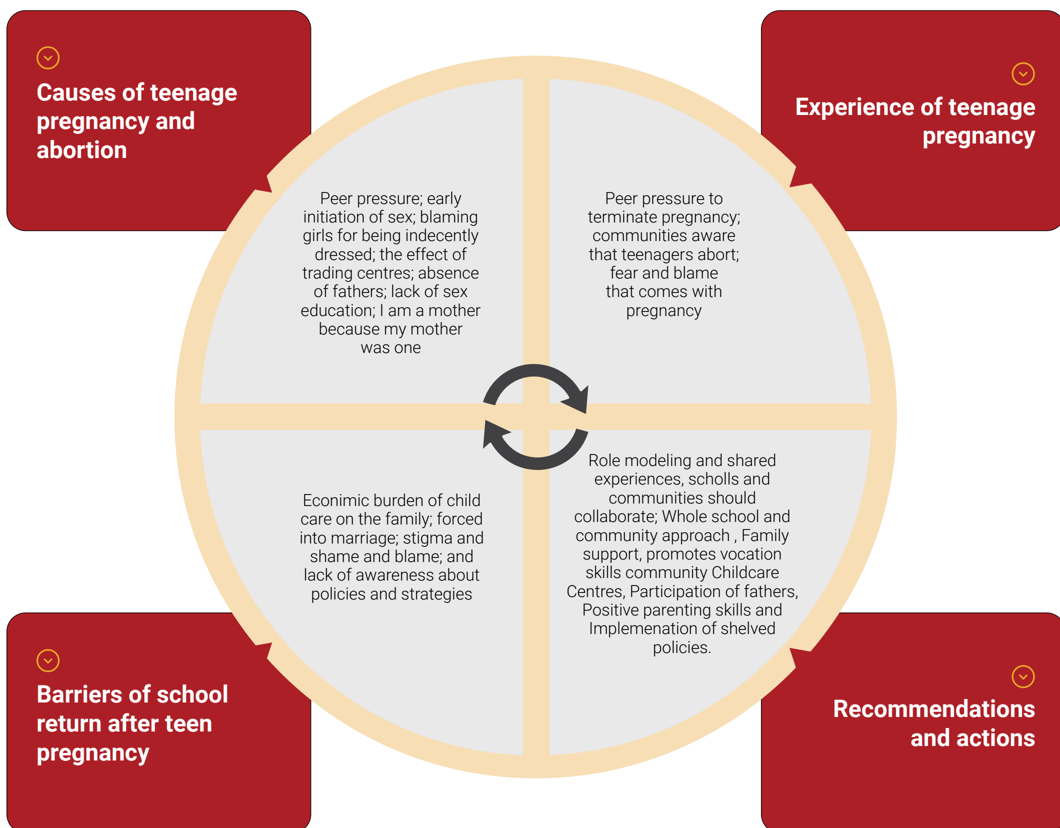
3.3 Causes of teenage pregnancy and abortion, and implications for girls' education, recommendations and actions

The qualitative data is organised under several thematic areas that emerged out of the code book, the themes highlight the causes of teenage pregnancy and abortion and the implications on girls' education and recommendations and actions to promote school return after pregnancy. The effects of COVID 19 on teen pregnancy are examined and explained. The causes of teenage pregnancy and abortion include peer pressure, early initiation of sex, blaming girls for indecent dressed coupled with the effect of trading centres, absence of fathers, lack of sex education and the intergenerational effect and social/family background as one noted;

> *I am a mother because my mother was one*

Specific to teenage abortion, there were expressions about peer pressure to terminate pregnancy and that communities are being aware that teenagers abort, the fear and blame that comes with pregnancy is an influencing factor. Girls who visit health facilities for post abortion care are discriminated against by health workers.

Figure 9: Findings on Causes of teenage pregnancy and abortion, and implications for girls' education, recommendations and actions



Teenage pregnancy further complicates the economic burdens of the family, many young girls are forced into marriage to avoid stigma, shame and blame from the community and lack of awareness and strategies on prevention and management of pregnancy in school.

This study provides recommendations and actions synthesised from the co-creation discussions that include role modeling and shared experiences, schools and communities' collaborative efforts, whole school and community approach, family support, promotion of vocational skills, community childcare centres, participation of fathers, parenting skills and implementation of shelved policies.

3.3.1 Causes of teenage pregnancy and abortion

Teenage pregnancy and abortion for this study was investigated in reference to the effects of Covid 19 because of the effects it paused. The other causes that emerged included girls being blamed for indecent dressing, absence of fathers, peer pressure, lack of sex education and the intergeneration effect of teenage pregnancy.

COVID 19 lockdowns, restrictions and the extended closure of schools: The pandemic emerged as a pivotal factor in driving teenage pregnancies, as expressed by the study participants. The prolonged closure of schools for close to two years provided adolescents with excessive idle time, coupled with limited parental supervision and protection and community failed protective values, many girls became pregnant. This situation occurred against the backdrop of challenging financial circumstances for parents and unrestricted access to social media – phones and television, young people moving free back and forth in trading centres where they came close to perpetuators and engagement in risky sexual behaviours. The following expressions show the extent of the challenges during the Covid 19 lockdown:

> « *Children were stuck at home, but many parents continued to work, and they left these children alone at home because parents had to continue to work to be able provide for the family. However, this meant that children remained alone. They were watching pornography and after that they want to experiment, they were going to meet men in the trading centre….* »
> Health worker 3 Mayuge

> « *Banange, can you imagine teenagers at home doing nothing at home for two years? You can't tell parents to supervise them because parents have to work. We have those trading centres; these days these people have phones where they are on social media and watching pornography. And even the sugar daddies were ready, and they really used our girls. Of course, COVID-19 really affected ehhh...* » health worker 1 Kamuli.

The other challenge was that the pandemic-related lockdowns and restrictions posed formidable barriers to accessing family planning services, risking unplanned pregnancy for those who would have wished to use contraceptives. Even for those who managed to do so, the absence of youth-friendly services at healthcare facilities presented an additional obstacle, including the discouraging attitude of health workers against providing contraceptives to young people as expressed below:

> « *Because of COVID lockdowns and they refused cars to move, it became hard for girls to come to town to get contraceptives. But also, because for some their parents were also at home and it made it hard to escape the house and so they ended up becoming pregnant because there was no family planning and some of us health workers tend not to accept that young people should use contraceptives.* » Health worker 2 Mayuge
>
> « *Sometimes when these girls come here, some health workers quarrel at them for getting spoilt and even judging them. And then you feel sorry for them because imagine everyone is looking at her. I think that's why some of them don't come to the health centre...* » Health worker 1 Kamuli.

Furthermore, the extended closure of schools exacerbated the risk of adolescent repeat pregnancies, there are many cases of young people who did not get pregnant once. The same factors which made the girls get the first pregnancy became worse and exposed the young girls to another pregnancy. The burdens of caring for the new born babies were on the family of the girl and in many cases fell on the girl alone. As some young girls are seeking assistance in caring for their babies, they found themselves vulnerable to manipulation by men offering financial and material support. This susceptibility increased the likelihood of these girls becoming involved in risky sexual activities, subsequently raising the chances of experiencing additional teenage pregnancies.

> « *There are some girls who got pregnant twice in this lockdown. The lockdown was so long, and you see after some girls gave birth, the problems which made them go for sex were still there and had even increased. And now they have a child so now you need money to take care of the child and so they went back to these men...* » Health worker 1 Mayuge.
>
> « *Some of these girls did not leave the men or boys who got them pregnant, here you will be advising her and she will just look at you and she will just go back. And it was easier to go back and get pregnant because remember they are still at home doing nothing and they need money to care for their babies...* » Stakeholder 4 Kamuli

As well, the lockdown is associated with an increase number of school dropouts for both girls and boys. The boys went to look for work in the form of manual labour and other" In opportunities that they found around the communities, in the eastern districts, it was expressed that *young people engaged in sugar cane plantations, boys who earned used their money to lure girls into sex*. In the following expression by one of the health workers, the escalation of teenage pregnancy was also associated with boys being able to work and earn money that they used to lure girls into sex because they could pay for it and the girls needed the money:

These sugarcane boys are becoming a problem. They are between 10 and 18 years and they make some money and confuse our girls. The number shot up during the pandemic and I think that was part of the problem Health worker 2 Mayuge.

Girls were blamed for indecent dressing and the effect of trading centres: Participants emphasized that young people, especially girls, face a heightened risk of sexual harassment, particularly noticeable in instances where girls wear revealing attire and move freely, even during nighttime visits to trading centres. This attire sometimes draws the attention of boys and men who may attempt to initiate sexual encounters. Stakeholders attributed this trend partially to parental involvement, criticizing parents for permitting their children to go outside the home in body-revealing clothes. They characterized such parental acquiescence as neglectful and careless, thus assigning some measure of responsibility to them for instance of adolescent pregnancy stemming from this behaviour. This was made worse by the fact that during the pandemic, teenagers spent a lot of time in the trading centres *dressed indecently exposing them to men at trading centres*.

One of the biggest challenge is these trading centres for instance Buwenge Mpya is one of the biggest and it operates all night and some of our children come from there. When you look at the dress code of the women from there, their dress code violates the Uganda law. They dress very indecently; they have no side clothes, and this causes rape. Stakeholder 6 Kamuli

Our girls dress so indecently these days, and they spend the whole day in the trading centres where you find people taking drugs and alcohol, betting and watching pornography so what do you expect…and at least in other times, but now in COVID when it used to happen every day and they could stay there even at 11 pm you find them Health worker 3 Mayuge

Nonetheless, during the second stakeholder meeting, one participant, while acknowledging this as parental neglect, expressed that it cannot be that girls who are sexually abused are blamed that it's because of their dressing, as expressed in the following quote:

…. we cannot keep blaming girls who are sexually harassed that it's because of their dressing, its lack of morals and promotion of abusive culture, let me give an example of the Karamajong community, where women and men traditionally wear clothing that exposes their chests and other body parts but with a strict code of conduct that teaches boundaries for body and spells out expected sexual behaviour. We cannot keep linking 'indecent' dressing with sexual abuse, we are blaming the victim instead of protecting them. Stakeholder 1 Wakiso.

Absent Fathers: The concern about the behaviours and morals of children, especially teenage pregnancy, repeatedly surfaced during stakeholder reflections. It was highlighted that fathers are frequently difficult to locate in matters related to care and concern. Stakeholders shared that fathers are often absent, preoccupied with activities outside the home, and engrossed in work and other economic pursuits. This situation leaves mothers with the primary responsibility for caring for and protecting children within the

home. In the community, mothers are judged and blamed when girls get pregnant before marriage or when they are school-going. The following expression is a narrative on the role of both mothers and fathers and that blaming mothers is not helpful:

> « *It is mothers who are not doing their job, you see here in Busoga most men go to look for money for food and school fees, so it is the role of the mother to make sure that these girls are making the right choices. But even these days mothers are neglecting their role and that's why you see things like this happening;* » Stakeholder 13 Kamuli
>
> « *You see the home is the first place where children learn and so before we blame the teacher or the government, we should start with the mother. Their girls are getting pregnant because they are not doing what they are supposed to do...* » Stakeholder 5 Kamuli

Peer Pressure and Early Sexual Initiation: Peers constitute a significant aspect of individuals' lives, particularly due to the shared experiences they undergo simultaneously. This influence wielded by peers has been expressed to be substantial in exposing young people to risky sexual behaviours leading to unplanned and unwanted pregnancies. Young people say the first sexual encounter is that they are allured in experimentation, driven by the perception that such experiences are pleasurable and requisite for attaining adulthood. Peer groups were one of the ways teenagers got themselves entertained as they were stuck at home, a breeding ground for experimentation and consequently, teenage pregnancies. The following quotes are the shared narrative by health workers and community members about the challenge of peer pressure:

> « *When there's one person in the group who has ever had sex and says it is enjoyable, it encourages the others to also want to experiment. They also want to see what is enjoyable and that's how they end up getting pregnant* » Health worker 2 Wakiso.
>
> « *Some of their friends have told them that you are not yet a woman if you haven't had sex and because they feel like they want to be grown up, they engage in sex and that's how they end up pregnant* » Health worker 1 Wakiso.
>
> « *These teenagers have bad groups, and the problem is everyone wants to be part of the bad groups. Those are the ones who always have money and seem to know everything. They are the ones who connect their friends to sugar daddies and boda men even* » Health worker 1 Mayuge.

Lack of Sex Education: The inadequacy of sex education has emerged as a seminal facilitator contributing substantively to adolescent pregnancies during the covid 19 lockdown. Central to this issue is that there was already limited sex education which was being received from school. Moreover, a prevalent misperception entrenched within the communities against what to include in sexuality education and the lack of the culture and arrangement to talk about growing up by parents and families exposed young people to being unaware of safe behaviours, attitudes and practices and they thus lacked information that would inherently shield them from the repercussions of pregnancy, engendering a disposition towards sexual activities devoid of prudence and precaution. The following are expressions on the same:

Most of these girls think they are too young to get pregnant and so getting pregnant is like an accident Health worker 1 Kamuli.

"They don't think you can get pregnant the first time and so some are shocked when they find out they are pregnant and yet they had sex only once Health Worker 3 Mayuge.

In addition to these factors, there is a clear lack of structured sexual education, which serves as a crucial foundation for addressing this complex issue. Adolescents are left to navigate through a confusing maze of misinformation, as accurate knowledge remains scarce and often overshadowed by unfounded beliefs and misconceptions. Within their peer networks, similar levels of ignorance is prevalent. Notably, a widespread misconception endorses the idea that using a common household detergent for post-coital cleansing can effectively eliminate sperm viability, serving as an improvised form of contraception. Similarly, there is a misleading notion that placing a specific object beneath the bed can act as a reliable barrier against conception as expressed in the following voices:

There was a girl, she said she got pregnant because they gave her a stick and told her if she put it under the bed, in the middle before having sex, she wouldn't get pregnant and so she was so shocked and could not believe it when she got pregnant Health worker 3 Waksio.

A young girl of 15 told me that her friends told her that they had heard that if you wash with jik after having sex, the sperms will die and so you cannot get pregnant Health worker 3 Mayuge.

Integration effect – *I am a young mother because my mother was one.*

It was revealed that most teen mothers are likely to have a history of their mothers having been young mothers making early parenthood to have an intergenerational issue. There are young mothers of young mothers. Young mothers will have been children of parents who gave birth when they were young, additionally, the young mothers themselves expressed limited experience in providing guidance and discussing sexual and reproductive health (SRH) matters with their children.

We have a grandmother of 32 years; she gave birth as a teenager and now her child is going through the same in this COVID period Stakeholder 7 Kamuli.

Young mother with 2 grandchildren. A lot of focus should be put on parenting. Empowering women is important. Stakeholder 2 Kamuli

Some parents dropped out of school while in primary and they got married and produced their children without knowing the value of education. At school, a child was punished because of speaking vernacular so the parent came quarrelling because they did not understand that speaking English is important. Most parents just take children to school to learn how to sign and write their names and they feel like that's enough. These same children are the ones who send them to cut sugarcane, get married and get pregnant early. They feel like education is a waste of time. Stakeholder 14 Kamuli.

3.3.2 Drivers of teenage abortion

The other factor is what communities express themselves about teenage abortion and the findings there are expressions about the peers to terminate the pregnancy, as well communities being aware that adolescents abort because of fear of shame and blame that comes with keeping the pregnancy outside marriage, adolescents engaged in risky abortion.

Peer influence to abort/terminate a pregnancy: For adolescents, companionship holds an unparalleled significance, transcending into a realm where friends take centre stage as the primary wellspring of information on their decision to abort. When a young girl gets pregnant, she will most likely turn to her peers for advice on what to do, even in the presence of parents and other senior people in their lives. Young people shape each other's choices to terminate a pregnancy, many times because they fear the adults, as expressed in the following quote.

> « *Peer pressure is a big problem; you find the friends have done it before or know someone who has done it before and so they will encourage their friend to also abort. Remember already they are fearing that their parents will chase them from home and even stop paying school fees, so at that time, it is the best option, and they have their friends to help them.* » Health worker 1 Mayuge.

Community's awareness about teenage abortion: Unless it is done to save the lives of a mother and conducted by an approved health worker, terminating a pregnancy in Uganda is an illegal act. When asked about post-abortion care, health workers expressed that young people always present themselves for post-abortion care, after they have started the procedures elsewhere. The health workers who meet these young people attest to the fact that the procedures are risky, young people use sharp materials inserted in the uterus to induce an abortion, they use materials such as metal hangers, or seek assistance from unqualified practitioners, colloquially referred to as *"quack doctors."* The following narrative expressions affirm that communities are aware that young people engage in risky acts of abortion:

> « *Remember I told you that people here are very poor, even for these girls to get pregnant it was some man who just gave her like 1,500 UGX. Now you imagine abortion to do it properly in some clinics is more than 100,000 where are they going to get that money, and so they would rather use those herbs or the hanger* » Health worker 1 Mayuge.
>
> « *The problem is most of them come when it is late. They have overbled and even have sepsis and so it becomes hard to manage and sometimes we lose them.* » Health worker 2 Mayuge
>
> « *You know they first hide because they fear that if they talk, they will find out that they are pregnant. So, by the time they reach here, the situation is not good, you find the girl has overbled and some of them don't have proper support, so you find the grandmother because the parents have chased her from home* » Health worker 3 Mayuge.
>
> « *There are some clinics that do abortions, but they are expensive, but I can't talk about them because I fear, you know abortion is illegal...* » Health worker 2 Wakiso.

Fear of shame and the blame that comes with a pregnancy: Because they fear being shamed and blamed, young people given chance chose to abort. Additionally, being pregnant carries the looming risk of being chased from school and left to care for the baby alone, all these conditions and experiences, leave young people with no option but to engage in risky abortion. The following is an expression of the push factors for abortion:

> *Remember many parents are poor and then you become pregnant, it is as if you are just wasting school fees. So, the children know that the parents will be angry and so abortion there works for them. And you know our parents, they will cane you and even chase you. And also, it will be the end of school fees. Even if I was the one, abortion would be an option.* Health worker 2 Mayuge.

> *We parents can be tough when we find out that our daughter has got pregnant, and we say things like I will chase you away and you want to beat them so badly. But it's because of the shock and disappointment. We are human beings too; you have to understand.* Stakeholder 15 Wakiso

Stigma and discrimination from health workers: Several respondents indicated that healthcare workers stigmatized the patients, labelling them as criminals and insisting on the provision of a police report before attending to their medical needs.

> *One time the doctor refused to help a patient who came in for post abortion care. He said abortion is a crime and until we show him her police report, he will not touch her, we had to wait for another doctor to come in and help her.* Health worker 2 Wakiso

> *Some of the health workers fear to deal with cases of abortion because all they know is it is illegal. Some will help the patient but will not record and others won't. And then some don't even know that we are supposed to do post abortion care. You just talk about abortion, and they get scared* Health worker 3 Kamuli.

3.3.4 Barriers of girls' school return after pregnancy

Families, communities and leaders expressed optimism and interest in providing opportunities to school re-entry after pregnancy and discussed the barriers at different levels. Throughout the discussions, divergent views were expressed regarding the methods and timing for school return after pregnancy. The barriers to school return after pregnancy are multidimensional and one leads to another, they range from the economic standing of the family, community stigma and ignorance and shelving of relevant policies. Barriers to school return shared by respondents are outlined below:

Teenage pregnancy is an added economic burden to the family: It is children from families with low social economic background that are at the same time faced with the challenges of teenage pregnancy. This is because families are already struggling to pay school fees, and they will tend to abandon the girl when she becomes pregnant. Some participants noted that when certain teenage girls became pregnant, their parents viewed it with a sense of relief, as they were no longer burdened with the financial responsibility of paying school fees for these girls and the teenager had even added another child, and so if the burden could be passed on to the person responsible for the child, they would be relieved.

Some parents are relieved because now they don't have to pay school fees anymore because of poverty, it is hard to convince such a parent about taking the girl back to school, but we have convinced a few. A girl got pregnant and was doing well but got pregnant in s3 and I talked to the mother to get the girl back to school. Plan international school took her up and she is now a teacher. Her mother had been sceptical because she was a widow and the girl's stepfather was not interested in the girl's education, but because we encouraged her. Stakeholder 3 Kamuli

Forced Marriage: Some parents make arrangements for their daughters to get married as a way of protecting the family from the shame that comes with pregnancy outside marriage, families compel girls to marry their perpetrators. The other benefit of arranging the marriage was that the family of the boy would pay the bride price, which is viewed as a source of pride and financial gain to the family. The following quotes are expressions of the forced marriage narrative:

Some parents force these girls to get married to their perpetrators because they know they will get some money and you remember I told you how poverty is a big problem here. It is the one that is causing all these problems Health worker 1 Mayuge.

I can give you the statistics for defilement cases in Kamuli from January 2023 for example. Teen pregnancies in January were 11 cases, taken to court 3, and those put away and bribed were 8 cases. Feb 22 cases, 4 cases to court, 14 were abandoned, lack of evidence, witnesses failed to turn up. March 16 cases, 14 were put away, 7 cases were reported, also they gave the wrong phone number. April 11 cases, 6 were put away. May 9 cases were reported, 4 were put in court, 4 have been put away. June 12, 8 in court and 4 still under inquiry. July 10 cases reported, 2 put to court, 5 under review, 3 abandoned. August the number has increased and is the highest so far and yet the month has not ended. Most are defilement cases. Cases of defilement as a source of income. They don't give them a lot of money; they even reach the court but there are no witnesses. When a child gets pregnant, for a father it is an advantage as it won't be his responsibility this is why they are married off. Stakeholder 1 Kamuli

Community Stigma

In the community, when a girl becomes pregnant before marriage, her family, particularly her mother, is subjected to negative judgment. This community stigma involves isolating the family to shield unmarried girls from perceived bad influences, and the mother is often criticized and blamed for being perceived as neglectful and left to cope with the consequences of the pregnancy alone. Community stigma also extended to school so these girls cannot be allowed in school.

In the community, they will use your child as a bad example, and even her friends will be laughing at her. You lose friends because parents will tell their children not to associate with you and so it becomes very difficult for the teenager and yet that's the time when they need help. Health worker 3 Wakiso

Especially the mother also gets a lot of criticism from the community and even from the husband. They say you are the one who made her get pregnant because you did not raise her well and so also her, she abandons the girl and yet she is the key person to help in that situation Stakeholder 3 Kamuli.

The truth is that they will come to school and spoil our children, I say that without fear of being quoted, and the worst part is that some of them want to come back to the same school and so that is still a challenge. We have to find another way of doing it Stakeholder 9 Wakiso.

Lack of awareness about policies and strategies

The government of Uganda is among the countries that expressed commitment to inclusive learning environments that provide universal education at primary and secondary levels. However, there was an expressed lack of awareness regarding government policies about the reintegration of teenage mothers into the educational system. In Kamuli, some participants expressed that they were aware of the policy but the stakeholders in Wakiso, said they know of the policy but not the content. Participants expressed dissatisfaction with the government's approach, noting that while policies were formulated, insufficient attention was paid to their implementation. Consequently, many remained unaware of these policies, despite their potential to provide critical guidance on the process of reintegrating teenage mothers and pregnant teenagers into the education system. The following are verbatim quotes on the challenge of failed implementation of policies:

Policies exist but most schools are not aware, as the District Education Officer, I am aware, but schools are not aware. Stakeholder 7 Kamuli

The government spends a lot of money making these policies, but they don't want to spend any money on sensitization. Even when they decide to sensitize, they give you one or two days and yet they have taken months to develop it. And as you can see no one here knows about it and that's the biggest problem with these policies, we don't know that they are there. Stakeholder 5 Wakiso

3.3.5 Recommendations and Actions for School Re-entry after Pregnancy

Two co-creation events were organized in the districts of Wakiso and Kamuli where to engage stakeholders to reflect on recommendations and actions to prevent teenage pregnancy and abortion and provide insights into school return after teenage pregnancy. The co-creation discussions were based on the preliminary findings to develop ideas and insights into the recommendations and actions that are based on evidence.

Role modelling and sharing experiences: In the Wakiso district, they shared the contribution of the Uganda Single Mothers Association, a local non-government organization that worked with community leaders to motivate young mothers to return to school. The following is the quote highlighting the contribution of the association because of their shared common stories about being a young mother:

The members of the Single Mothers Association shared their stories to motivate in this endeavour, teenage mothers have been employed as role models to demonstrate to both expectant teenage girls and their parents that achieving success is feasible even after experiencing teenage motherhood. Stakeholder 8 Wakiso.

I think most of you who live here have heard about the single mothers association, they have helped us so much. They have acted as role models to show young girls that giving birth is not the end, you can go back and become something. So, if government and organisations like yours could work with such people, we could help Stakeholder 15 Wakiso.

Collaborative efforts by the Schools and Communities: In Kamuli District, stakeholders shared accounts where teen mothers were granted the opportunity to complete their end of primary and secondary levels. Schools collaborated closely with community leaders to identify pregnant teenagers and teenage mothers, to bring the young mothers and pregnant students to complete their exams, as a result, the community and the schools shared positive testimonies of good performance and school completion. The following quotes are some of the stories:

There were 12 cases of teen mothers sitting for PLE as such there is a need for sensitization of allowing teen mothers to go back to school. We worked with the LCs, and we found these girls and we brought them to sit their exams Stakeholder 7 Kamuli.

There is one who we put back in school, but we had to take her to another school where they don't know her to reduce the stigma. When it was time to give birth, she left and then came back when she was ready to start again. I know that it is possible Stakeholder 8 Kamuli

Whole school and community approach coupled with family and peer support: In certain communities, peer-to-peer groups were found to positively contribute to school return and completion after pregnancy. Peer support was found to serve two purposes: preventing pregnancies among those who have not experienced them yet, assisting individuals who are already pregnant in preventing subsequent pregnancies, and providing support to those seeking a return to education. An essential component of this approach was the active participation of parents and a supportive school environment school, where parents, teachers and leaders – religious and political engage as expressed in the following quotes:

Peer-to-peer mentoring also can work. Here PLAN International is working with some schools on peer-to-peer mentoring. But we have to supervise them because I know some groups where the children were instead learning bad manners Stakeholder 5 Kamuli.

I do not see any cultural leaders in this meeting and yet they are very influential and can be very helpful. They can change the narrative around child marriages and even compensation by perpetrators and instead work with the law enforcers. And I am glad today we have religious leaders here because they too are important in these discussions. Stakeholder 2 Wakiso.

> *The way sensitization has been going on hasn't been handled correctly. There is a need to start from the grassroots involving Lc1, 2, and 3 to help out. Schools focus on only children and leave out teachers, they intimidate and don't involve them. There's needed to sensitize teachers, we might not need the political wing.* Stakeholder 11 Kamuli.

Providing sexual and reproductive health education: Participants highlighted the importance of sexuality education; young people need to learn about how to prevent pregnancy. For young mothers, sex education should encompass mental health, recognizing that these young individuals are undergoing a traumatic experience and require adequate preparation before returning to school. Counselling and mental health support also emerged as crucial elements of any support system. Given that these teenagers have transitioned into the role of mothers, a responsibility that will remain with them, it is essential to provide guidance and assistance to help them adapt to this new role. The following are supporting quotes to this finding:

> *We need to advocate for sensitization on sex education, addressing mental health support for teen mothers, and engaging them before they return to school to avoid traumatic experiences.* Stakeholder 3 Wakiso
>
> *We need outreaches in the community where we can do sex education for these teenagers both in school and out of school. As the hospital now we don't have enough resources, but we are willing if the resources are made available* Health Worker 1 Mayuge.

Some participants advocated for ongoing counselling and guidance, highlighting the necessity for continuous support rather than a one-time event. Additionally, religious organizations were urged to expand their counselling services to include teenage mothers, as their focus had traditionally centered on counselling couples. Religious representatives who attended the stakeholder meetings expressed their willingness to actively contribute to the prevention of teenage pregnancy and the facilitation of pregnant girls' return to school. They emphasized their substantial community influence and following, making them influential agents of change who had, thus far, been underutilized.

> *Bring religious leaders on board, they can do it, once a follower believes in their leader, whatever the leader says, the follower will do as he/she is told.* Stakeholder 11 Kamuli

Participation of Fathers/male parents: Stakeholders pointed out a notable limitation in the prevailing discourse, which is predominantly centred on girls and mothers. They stressed that the blame, shame, and solutions primarily targeted girls and their mothers, even though boys and fathers also played a significant role in these pregnancies. Consequently, it was proposed that all sex education efforts and interventions should incorporate boys, men and fathers as integral actors. The expression was that ...*it is not possible to prevent pregnancy and support school return strategies without involving fathers.*

> *There's a need for community dialogues, talk to men to be model fathers, where they can protect children. Men need to be involved in raising their children and not leave it to the women.* Stakeholder 5 Kamuli

> *Men are working and so women are idle at home and so we need to empower these women. Financial empowerment is not the same as being educated. And you know these women if they have money can educate their daughters, but they are financially challenged. And what makes it worse is when they go to ask these men for money for food or school fees, it brings about domestic violence* Stakeholder 1 Kamuli

Promoting Parenting skills and sexual and reproductive skills: Suggestions were made to educate parents on sexual and reproductive health issues and teach them how to talk to their children about these issues because most parents were not talking about it. The grandparents and aunties who were charged with the role in the past are not available as the family structure has changed due to social economic changes and so parents need to be at the centre of sex education, and they need to be helped to get into the role.

> *Parents fear talking to their children about these issues. Some of them have left the role to the teachers because of this and yet it is the main role of the parent. And so, I think one of the important things that can be done is to teach these parents how to talk to their children.* Stakeholder 3 Kamuli

> *Those days when we were growing up, there were bonfires under which our leaders would talk to us about growing-up issues. These days those things don't happen anymore and yet they used to be very important. And even the grandparents who used to talk to us are not with us, we have been separated they live in the village, we are in town* Stakeholder 2 Wakiso.

> *Support systems begin from home. The parents talk to their children early enough about sex and love. At 12 and 13 years, talk to them about the likely challenges so they will be able to understand us. If you bend a musambya tree when it is still young, it will never be straight, I think if we talked to children early, they wouldn't go astray. For instance, when I was in p5, my teacher told me that HIV doesn't kill it's the diseases that kill and that has stuck with me to today.* Stakeholder 5 Kamuli

Implementation of "unimplemented laws: Girl child stakeholders at the implementation level such as teachers, parents, local council politicians and the technical teams and health workers claim to not be informed of the national guidelines on adolescent sexual and reproductive health including child protection against violence. Across all the discussions and interviews, the stakeholders expressed discontentment with the Ministry of Education's preoccupation with developing policies that were never implemented successfully. In the following quotes, the expressions are quoted to provide the verbatim narrative on *shelved policies* that are never implemented:

...the ministry is always developing policies that come and pass, the revised policy on prevention and management of teenage pregnancy in school was launched but the government did not even provide strategies and plans to get the policy implemented, we tried as politicians to support the young mothers to return to school but this was at a personal level. This policy will also be on shelve like the one on sexuality education.... Stakeholder 4 Wakiso

Some of these policies are unrealistic for example in our case we have argued parents to be involved in the lives of their children, not realistic for the government to offer a capitation of the grant of less than 2000 shilling to feed a student at school for a day, in the name of getting parents to believe that education is free, for us we get the students to pay and support school services.... Stakeholder 10 Wakiso

These stakeholders recognized the potential benefits of well-informed community participants and, accordingly, recommended that the Ministry of Education initiate an extensive awareness and education campaign regarding the existing policy to enhance its utility within the community. Additionally, they underscored the importance of incorporating community concerns into policy revisions to enhance practicality and effectiveness. Notably, they stressed the pivotal role of parents in the decision-making process related to the reintegration of girls into the educational system and suggested their inclusion as important stakeholders.

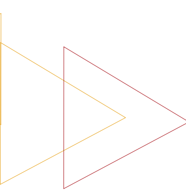
I can see that the policy is revised, what are they revising when we don't even know about the policy and that is the problem? These policies remain up there and the people who need it never get to know about it. There is a need to involve the communities down here if it is to work out.. Stakeholder 1 Wakiso

Promote vocational training: Participants emphasized the need to expand educational options beyond traditional formal schooling, recognizing that many parents lack the means to reintegrate teenagers into conventional educational systems. Consequently, skill-based learning, such as tailoring, baking, mechanics, and similar practical vocations, was deemed more appropriate. This approach held particular relevance because teenage mothers often must support their newborn children, making it essential for them to acquire skills that enable them to generate income.

We are concentrating too much on going back to school, but some people cannot afford that, so we could also think of vocational training like tailoring and baking. You have to remember that they also have to take care of their children" Stakeholder 4 Kamuli

The parents have other children and are poor, we have to think about skills training like tailoring for these girls so that even those who cannot go back to school are not left out. And skills training is cheaper, and it takes a shorter time, and the girl can earn when she finishes so parents might be more open to that. Stakeholder 1 Wakiso

Create Community Childcare Centres: One of the reasons why young mothers are not comfortable returning to school is that they need to care for their children, community childcare centres would provide a support structure for young mothers to be able to take time to study. These community centres served as a safe space for the children during the mothers' school hours and allowed them to be reunited in the evenings. This concept offered a pragmatic and feasible solution that, if effectively coordinated between the Ministry of Education and the community, could facilitate the return of teenage mothers to school without neglecting their maternal responsibilities.



4.0 IMPLICATIONS AND CONCLUSIONS

Uganda, like the rest of the countries in the region recorded high rates of teenage pregnancy among school-going teenagers during the 18 months when schools were closed to prevent the spread of Covid 19. More girls especially very young adolescents (aged 10 to 14 years) dropped out of school due to pregnancy during the Covid 19 lockdown in Uganda (FAWE, 2021; Nyakato et al., 2021).

Regardless of the presence of the COVID-19 pandemic, it is evident that teenage pregnancy is an issue that continues to persist with varying effects on girls' education. Notably, the pandemic exacerbated an already dire situation and there was reactionary response at policy and community levels that has not translated into effective strategies for girls' education after pregnancy.

The findings of the study agree with previous findings on the five (5) barriers to girls' education after pregnancy and these have remained consistent with the second phase of the study. These are **negative self-perception, childcare burdens, community and family tensions, a tense school environment and ineffective policies (Nyakato et al., 2022). The review of health centre records under the study extension** reveals a higher prevalence of reported abortions among adolescents in Wakiso compared to Mayuge and Kamuli, yet Mayuge leads in terms of overall deliveries, encompassing both adolescents and older mothers, as well as abortions among older mothers. These disparities may be attributed to socio-economic factors, including forced marriages and poverty, which likely contribute to this complex scenario.

Teenage pregnancy continues to raise societal blame and stigmatization, resulting in a cascade of violence directed at young expectant mothers. Mistreatment persists throughout and beyond pregnancy, emanating not only from within the family but also from community members and even healthcare professionals who, ideally, should constitute their support network. Adverse conditions manifest into adverse outcomes, including school dropouts, early marriage, abortions, recurrent pregnancies and sexual and gender-based violence. These findings agree with similar studies conducted in Uganda and across sub-Saharan Africa (Chigona & Chetty, 2008; Coast et al., 2021; Nabugoomu, 2019).

The data on abortion is derived from the healthcare facilities' records on post-abortion care because of the illegality and unavailability of abortion services. Consequently, our study relied on data concerning post-abortion care, which indicated the presence of underground abortion services in certain clinics. The burden of teenage pregnancy continue to push girls to conduct risky abortions, with hopes of rushing to health facilities to seek post-abortion care. The findings are in agreement with other studies which indicate that post-abortion care is offered but surrounded with stigma and being judged (Aantjes, Gilmoor, Syurina, & Crankshaw, 2018; Atuyambe, Mirembe, Johansson, Kirumira, & Faxelid, 2005). Additionally, the experience of seeking post-abortion care was marred by the stigma perpetuated by judgmental healthcare providers toward teenagers who had undergone abortions (Paul, Gemzell-Danielsson, Kiggundu, Namugenyi, & Klingberg-Allvin, 2014).

While it is a service offered under obstetric care and support, it was difficult to collect records on post-abortion care across all the health facilities that were enrolled in the study, the records were scanty and

unavailable, and this was attributed to inadequate record-keeping practices, this could also imply to the fact that abortion is illegal and stigmatized (Bukenya, Mulogo, Kibira, Muhumuza, & Atuyambe, 2017).

The desire to continue with education post-pregnancy is evident, nevertheless, the absence of a comprehensive strategy and contextualized policies poses a significant challenge. The mere presence of policies on paper does not suffice, it is the successful implementation of these policies that marks their effectiveness. It is important that existing policies, such as the revised guidelines on prevention and management of pregnancy in school, the accelerated education program, vocational training initiatives, and sexuality education the implemented through the identification of gaps in their execution (MOE, 2019). The findings of this report agree with previous studies that recommend an in-depth examination of the efficiency and effectiveness of the policies and why they often remain underutilized or unimplemented (Ejuu, 2012; Ninsiima et al., 2020).

Conclusion

The postnatal care records revealed that during the COVID-19 period when schools were closed, the three districts of Mayuge, Kamuli and Wakiso recorded increased deliveries among adolescents. Most of the adolescent deliveries were recorded in the Mayuge district, followed by Kamuli and lastly Wakiso district.

There is scant information on post-abortion care as per the health facility records, data on post-abortion care was only available only in two facilities assessed in Kamuli and only one facility in Mayuge and 1 in Wakiso. Wakiso recorded more women that visited the health facilities seeking post-abortion care, the second highest was Mayuge district and lastly Kamuli.

The key causes of teenage pregnancy reported included peer pressure, early initiation of sex, blaming girls for indecent dressing coupled with the effect of trading centres, absence of fathers, lack of sex education and the intergeneration effect – *I am a mother because my mother was one*.

The challenges of teenage abortion include peer pressure to terminate pregnancy; communities being aware that teenagers terminate the pregnancy; and the fear and blame that comes with pregnancy. Girls who visit health facilities for post-abortion care tend to feel discriminated against by health workers.

Several factors hinder school return after pregnancy and these include childcare economic burdens on the family, many young girls are forced into marriage to avoid stigma shame and blame from the community and lack of awareness and strategies on prevention and management of pregnancy in school.

Providing after-pregnancy educational opportunities will undoubtedly contribute to the pursuit of gender equality in education since their male counterparts are not affected by the same situation.

Denying young girls the chance to complete their education is a form of structural violence perpetrated by family, community, institutions, and policy.

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ANNEXES

Annex 1: Study Tools

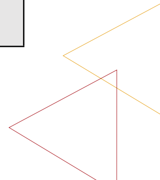
DATA COLLECTION TOOLS:

HEALTH FACILITY RECORDS' FORM FOR TEENAGER'S DELIVERIES/POST ANTENATAL CARE AND POST-ABORTION CARE

A: GENERAL INFORMATION ABOUT HEALTH FACILITY

This tool will be used for collecting general information on the Health Facility (HF) records on the number of adolescents who have given birth at the HF and Records on post-abortion care for the adolescents.		
General Information		
Name of the HF		Select the name from the drop list for 7
1. Health Facility Number	|___|___|___|	3-digit number e.g., 001
2. Location of HF (district)	|____________________|	Select the name of the district from the drop list of 3 districts (Wakiso, Mayuge, Kamuli)
3. Level of the HF	|___|	1=HCIII, 2=HCIV, 3=District Hospital 4=Regional Referral Hospital
4. Respondent's position at HF	1= Head of unit 2= Head of department 3= if other specify……………………………….	Ask the respondent for their position in HF and select the respective answer.
5. Respondent's gender (Head of unit/ department)	1=Male 2=Female	This applies to the gender of the in-charge or the delegated person that you are interviewing.
6. Respondent's Qualification (Head of unit/ department)	1= Specialist (specify)—————————— 2=Medical doctor 3=Clinical officer 4=Nursing officer 5=Enrolled midwife 6=Enrolled nurse 7=Other If Other, specify: ………………….	Select the respective qualification that corresponds to what the respondent reports. In the case of the "Specialist" option, specify the type of specialists e.g., Physician, Obstetrician, etc.

7. Respondent's highest academic qualification (Head of unit/ department)	1=PhD 2=Masters 3=Degree 4=Diploma 5=Certificate 6=Other If others, specify: …………………	Consider as the highest level of education the qualification the respondent reports to have either achieved or already in the process of achieving. **In case** of "other qualifications" besides the mentioned ones, specify the qualification in the space provided
8. How would you describe the road access to your HF?	1=Not all weather 2=All weather	Select "Not all weather" if the road may not be accessible in certain weather conditions e.g., during the rainy season. Select "All weather" if the road can be accessible in all weather conditions **wet or** dry seasons.
9. What is the population coverage of your HF?	|_____________|	Write the number in the provided space. This may be obtained from district or facility records. Ask the **in charge** of this.
10. What is your main type of electricity supply?	0 = No 1= Solar, 2= Hydro 3=Generator	Select the type of electricity that the respondent reports as the "mostly used". The RA should probe to ensure that the respondents report the 'Most used" electricity source.
11. Is there a mobile phone network?	a) Airtel: 0 = No, 1 = Yes b) MTN: 0 = No, 1 = Yes c) Lyca Mobile: 0 = No, 1 = Yes d)UTL: 0 = No, 1 = Yes e) Other: 0 = No, 1 = Yes If other, specify:|__________________|	On each of the respective mobile phone networks, ask whether it is available and select: "No" if the respondent reports that it is not available, or "Yes" if it is available. In case of any other network outside those mentioned, type in the free text space. NB: No mobile phone network should have either "No" or "Yes" selected.
12. What is the distance in KM of the next referral **centre?**	|___|___|___|km If the respondent is not sure, specify the Referral Health **Facility**: |___________________|	In this case, the next referral centre implies the health facility to which women or adolescents with obstetric complications are normally referred. Ask the respondent to estimate distance in kilometres. In case they can't tell the distance, make a note in your notebook of the name of the referral health facility to use Google Maps to estimate the distance later. Write a 3-digit number e.g., 001, 100 Km etc.
13. What is the Level of the next referral HF	1=Clinic, 2=HCII, 3=HCIII, 4=HCIV, 5=District Hospital 6= Regional referral Hospital	Ask the respondent for the level of the referral health facility and select the respective answer.



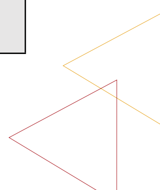
14. Does your health facility offer the following services?	a) Antenatal care: 0 = No, 1 = Yes b) Deliveries: 0 = No, 1 = Yes c) Post-natal care: 0 = No, 1 = Yes d) Post-abortion care: 0 = No, 1 = Yes e) Child immunization: 0 = No, 1 = Yes	Mention each service type to the respondent, asking for its availability and selecting: "No" if the respondent reports that it is not available, or "Yes" if it is available. NB: No service type should have either "No" or "Yes" selected.

B: HEALTH FACILITY RECORD ON TEEN DELIVERIES AND POST-ABORTION CARE (INFORMATION TO EXTRACT FROM HF REGISTERS)

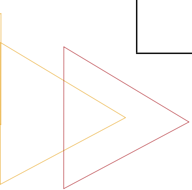
(Provide hardcopy of this section as well)

1. Total number of teenage mother deliveries seen in the last 6 months (Jan to June 2023) (check Postnatal, gynaecology registers)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Count from the register the number of teen mothers seen at the health facility in the last 6 months. Give separate numbers for all mothers but also for Adolescent mothers as per the categories.
2. Total number of teenage mother deliveries seen in the last 6 months (Jan to June 2022) (check Postnatal, gynaecology registers)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Count from the register the number of teen mothers seen at the health facility in the last 6 months. Give separate numbers for all mothers but also for Adolescent mothers as per the categories.

3. Total number of teenage mother deliveries in the last 6 months (Jan to June 2021) (check Postnatal, gynaecology registers)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………….	Count from the register the number of teen mothers seen at the health facility in the last 6 months. Give separate numbers for all mothers but also for Adolescent mothers as per the categories.
4. Total number of teenage mother deliveries seen in the last 6 months Oct 2019 to Mar 2020 COVID (check Postnatal, gynaecology registers)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………….	Count from the register the number of teen mothers seen at the health facility in the last 6 months. Give separate numbers for all mothers but also for Adolescent mothers as per the categories.
5. Total number of post-abortion teenage mothers seen in the last 6 months between Jan to June 2023 (Check post-abortion register)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___|	Count from the register (post-abortion) the number of post-abortion mothers seen at the health facility either immediately or within 6 weeks postnatal in the last 6 months.



Total number of post-abortion teenage mothers seen in the last 6 months between Jan to June 2023 (Check post-abortion register) *(continued from previous page)*	e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Give separate numbers for all mothers but also Adolescents.
6. Total number of post-abortion teenage mothers seen in the last 6 months Jan to June 2021 (Check post-abortion register)	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Count from the register (post-abortion) the number of post-abortion mothers seen at the health facility <u>either immediately or within 6 weeks postnatal</u> in the last 6 months. Give separate numbers for all mothers but also Adolescents.
7. Total number of post-abortion mothers seen in the last 6 months Jan to June 2022 (*check ANC, Postnatal, Gynecology and post-abortion registers)*	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Count from the register (post-abortion) the number of post-abortion mothers seen at the health facility <u>either immediately or within 6 weeks postnatal</u> in the last 6 months. Give separate numbers for all mothers but also Adolescents.



8. Total number of post-abortion teenage mothers seen in the last 6 months Jan to June 2023 (*check ANC, Postnatal, Gynecology and post-abortion registers)*	a. All mothers/ deliveries: |___|___|___|___| b. Adolescent mothers (10 to 12 years): |___|___|___|___| c. Adolescent mothers (13 to 14 years): |___|___|___|___| d. Adolescent mothers (15 to 16 years): |___|___|___|___| e. Adolescent mothers (17 to 18 years): |___|___|___|___| f. Adolescent mothers (19 to 20 years): Comment (number of complete months tallied and reason) …………………………	Count from the register (post-abortion) the number of post-abortion mothers seen at the health facility either immediately or within 6 weeks postnatal in the last 6 months. Give separate numbers for all mothers but also Adolescents.

INDIVIDUAL INTERVIEWS WITH HEALTH WORKERS

Introduction:

Thank you for the opportunity to speak with you. We are a research team interested in learning more about teenage pregnancies and abortions. We assure you that all the information that you provide to us will be used exclusively for our research and analysis. We will record the session, but all responses will appear anonymously. This is not a test, and there are no right or wrong answers. The most important thing is that you should feel comfortable and contribute as much as you can. You can express opinions and discuss issues freely.

A. **Participant Information:**

1. Name:
2. Sex:
3. Designation:
4. Health Facility/Organization:

B. **General Information about Teen Pregnancy and Post Abortion Care**

5. How long have you been working as a health worker? How long have you worked in the health facility?

(How long have you worked with teenagers)

6. What is your understanding and experiences of teenage pregnancy and post-abortion? – Needs, reasons/justification, community view of prevention of teen pregnancy, benefits and best-suited actors/who and how to provide support systems and services.

7. How did Covid 19 affect teenage pregnancy?

Teenage Pregnancy:

8. Have you personally encountered cases of teenage pregnancy in your work? If yes, could you share some of your experiences?

9. Were there any changes in teenage pregnancies before and after COVID? What influenced the changes?

10. What are the common health risks associated with teenage pregnancies?

11. How well-informed do you think teenagers are about contraception methods and reproductive health?

12. In your opinion, what role can health workers play in preventing teenage pregnancy?

13. How did COVID-19 (closure of schools) affect teenage pregnancy?

D. Post Abortion Care for Adolescents

14. What do you know about the laws and regulations regarding abortion in Uganda?

15. What is your comment on adolescents who seek post-abortion support and care? (Probe for the age range of adolescents seeking post-abortion care, reasons for seeking post-abortion care)

16. How did Covid 19 affect post-abortion among adolescents?

17. What are the main challenges for post-abortion care?

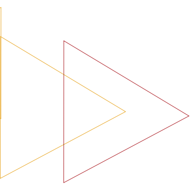
E. Support Systems and Interventions:

18. Are there any existing support systems or interventions for teenage pregnancy prevention or post-pregnancy support that you are involved in?

19. How effective do you think these interventions are, and what are their limitations?

3. In your opinion, what additional support or interventions are needed to address the challenges faced by teenage mothers?

THANK YOU FOR YOUR PARTICIPATION AND TIME



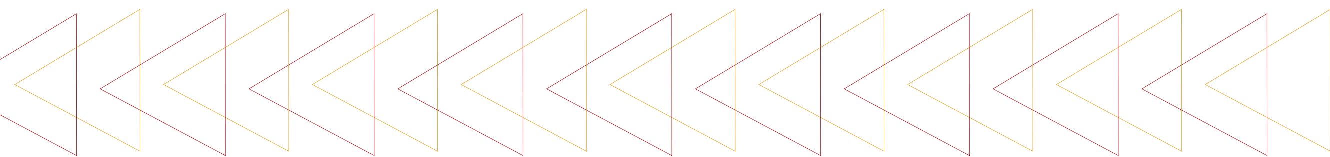
Co-creation Discussion Guide

In 2020, the Ministry of Education and Sports provided revised guidelines to facilitate school re-entry.

a. Are the guidelines being implemented? If yes how? If not what are the barriers?

b. Should girls be given a second chance to return to school after pregnancy? Why and how?

c. What support systems can be implemented within schools and communities for pregnant teenagers to improve access to education after teen pregnancy?



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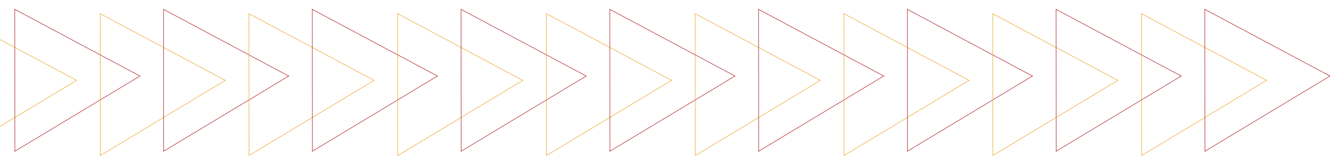

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