

# **TEEN MOTHERS ASSESSMENT REPORT,**

**Mukono district Uganda**

**A review of the reality**

**Prepared by**

**CCAYEF**

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**2014-2017**

## **Introduction**

### **1.1.Preamble and key facts on teenage pregnancy**

Teenage Pregnancy is visible yet taken to be invisible; we observe it in our living rooms almost every day, if you're not a victim, you're affected, much as many see it as a personal/ family issue; but its indeed a social public threat, it deters national and personal development. It has become an important health issue of advocacy in a great number of districts in Uganda, Mukono not excluded.

The term “teenager” is often used synonymously with “adolescent”. In this sense “teenage pregnancy” means pregnancy in a woman aged 12–19 years. Pregnancy in teenagers (girls below 19years of age) is by no means a new phenomenon. In many Western societies over the last century, the incidence of sexual intercourse among teenagers and the number of pregnancies sharply increased, especially after the Second World War. In the 1960s and 1970s both society at large and health authorities increasingly viewed the growing numbers of teenage pregnancies as a problem. Comparable developments took place in many developing countries (e.g. in sub-Saharan Africa and Latin America) and in many of these countries there has been a gradual shift away from extended family structures and towards nuclear families. With this change in family structure and way of living, the role of members in the hitherto extended family in educating and acting as role models for young people in sexual behaviours has disappeared (Ojwang&Maggwa, 1991).

Two key events during teenage stage have strongly influenced these developments. The first is the changing age at menarche, with median age varying substantially among populations (ranging from about 12.5 years in contemporary Western countries to more than 15 years in poor developing countries; Becker, 1993). Historical data from the USA and several European countries show a clear secular trend, with age at menarche declining at a rate of 2–3 months per decade since the 19th century, resulting in overall declines of about three years (Wyshak& Frisch, 1982; Bongaarts& Cohen, 1998). In developing countries, age at menarche is often inversely correlated with socioeconomic status, and significant differences exist between urban and rural populations, and between high- and low-income groups (Marshall & Tanner, 1986). The timing of menarche in populations is probably affected by a variety of environmental,

genetic, and socioeconomic factors, but most analysts consider nutritional status to be the dominant determinant (Bongaarts, 1980; Gray, 1983; Bongaarts& Cohen, 1998).

The second key event influencing teenagers is schooling. Education leads to social and economic benefits for individuals, and in Western countries in the last century, the prevalence of secondary schooling during adolescence has markedly increased, and in developing countries in the past four decades school attendance has also risen substantially. One implication of these trends is that a larger proportion of the period of teenage stage for boys and girls is spent in school (Bongaarts& Cohen, 1998). Such increased schooling has made teenagers less dependent on parents and family, and has postponed the age at marriage, and thereby the age of socially sanctioned sexual relations (see also section 3.8).

Both these events (declining age at menarche and increased schooling) have prolonged the period of teenagers. Together with a growing independence from parents and families, this has led in recent decades to more premarital sexual relations and increasing numbers of teenage pregnancies.

## **1.2. Aims and content of this review**

For the last 10 years, CCAYEF has been supporting adolescent girls; victims of sexual violence; and young mothers to become empowered, resilient, determined, safe and take steps to self-sufficiency. For the purpose of ascertaining information that informs the strategy design and therapy for these clients, their caretakers and babies, CCAYEF put in place a data base to gather information. The information presented in this document, was entered from January 2014 to May 2017, and the source of data is the “**CCAYEF Teenage Mothers’ Assessment Form ‘A’**”.

## **1.3.This assessment aims;**

- i) To access information for supporting programs on pregnant adolescents to have health pregnancies, become better parents and take steps to self-sufficient in the district.
- ii) To provide information that could be used to Empower child brides into resilient, powerful, determined and self-sufficient individuals, who can adequately fight for their rights.
- iii) To guide on strategies of creating awareness among communities about girl child sexual reproductive health rights, to facilitate reduction of incidences of teenage first and second unwanted pregnancies and improve on the age of first conception among teens.

- iv) To provide information that could facilitate Advocating for policy change for inclusion of teenage girl rights, especially for victims of sexual violence.

To achieve these aims a search of the literature has been made from both developed and developing countries. This literature has been critically reviewed, with special attention given to the differences between adults and adolescents, the complications and outcomes of their pregnancies and to the care received during pregnancy, labour and the postpartum period. Attention has also been given to the literature on the social background of teenager's pregnancies. In selecting the relevant literature, preference has been given to population and community-based data and to methodologically sound research. Most studies that meet these conditions are carried out in large centers in the USA, Western Europe and other developed countries, but excellent research data are also available from developing countries such as India, and from some countries in Africa and Latin America. Nevertheless, confining this review to methodologically reliable research alone would still cause an imbalance in the available evidence; an effort has therefore been made to include other data from other sources, this can provide interesting information, they may also be biased because in many instances mainly in developing countries many pregnant women deliver at home and only go to a hospital in case of emergency. Even in developed countries where almost all pregnant women deliver in hospital, there are still referral biases causing differences between hospital populations.

## **2.0. Incidence of teenage pregnancies**

### **2.1.Global Incidences**

The magnitude of the issue of teenage pregnancy can be better understood by looking at evidence from different surveys on the percentage of women aged 20 to 24 who had a live birth by age 15 or 18. The most recent estimate available indicates that almost one in five women aged 20 to 24 (19 per cent) had a live birth by their 18th birthday (UNFPA, 2013). An equivalent value of 3 per cent was observed for those who had the live birth by age 15. As with many averages, there are substantial variations across different regions. For the before age 18 figure, extreme values are observed in sub Saharan Africa, at 28 per cent in West and Central Africa, and 25 per cent in Eastern and Southern Africa, compared to just 4 per cent in Eastern Europe

and Central Asia. By contrast, Latin America and the Caribbean show a value close to the global estimates at around 18 per cent.

Among the 10 countries with the highest prevalence of pregnancy among adolescent girls in both relative and absolute terms, Niger has the highest percentage of women aged 20 to 24 with a live birth before age 18, at 51 per cent, India in 2010 had the highest total number at 12 million. In addition to that, there are 30 additional countries where the percentage is 20 per cent or more, a value that is high and unacceptable overall.

In absolute terms, in 2010, 36.4 million women aged 20 to 24 had their first live birth before age 18, and 5.6 million did so before age 15. This value is equivalent to 7.3 million girls under the age of 18 giving birth every year, (UNFPA 2013). Of the 36.4 million, almost half or 17.4 million adolescent mothers lived in South Asia. Sub-Saharan Africa, with the highest prevalence of pregnancies among adolescent girls, accounted for 28 per cent of adolescent mothers, with 15 per cent in West and Central Africa, and 13 per cent in Eastern and Southern Africa.

There are 40 countries where 20 per cent or more of women aged 20 to 24 gave birth before age 18. Of the 15 countries where the figure is over 30 per cent, 14 are in sub-Saharan Africa, with the highest rates observed in Niger (51 per cent), Chad (48 per cent), Mali (46 per cent), Guinea (44 per cent), Mozambique (42 per cent), Sierra Leone (38 per cent), Liberia (38 per cent), Central African Republic (38 per cent), Madagascar (36 per cent), Gabon (35 per cent), Malawi (35 per cent), Zambia (34 per cent), Uganda (33 per cent) and Cameroon (30 per cent). The only country that has a rate above 30 per cent outside sub-Saharan Africa is Bangladesh at 40 per cent.

Over the recent past, the global prevalence of pregnancies among girls less than 18 years of age has slightly declined, by 14 per cent, from 23.3 per cent to 20.1 per cent (see Figure 4.3). All regions, with the

Despite some progress towards reducing pregnancies among adolescent girls, the disparity between sub-Saharan Africa, particularly West and Central Africa, and other regions has grown. Among those countries that conducted surveys during 1990 to 2008, a woman aged 20 to 24 in West and Central Africa faced a probability of giving birth before age 18 that was 1.1 times as likely as a woman in South Asia, 2.7 times as a woman in the Arab States, and 4 times as a woman in Eastern Europe and Central Asia. Around the second period, 1997 to 2011, these

probabilities increased to 1.3 times, 2.9 times and 4.9 times those of South Asia, the Arab States, and Eastern Europe and Central Asia, respectively.

## **2.2.National incidence (Uganda)**

According to Uganda Demographic and Health Survey 2016, 25 percent of adolescents age 15-19 in Uganda have begun childbearing: 19 percent of women age 15-19 have given birth, and another 5 percent were pregnant with their first child at the time of the survey. As expected, the proportion of women age 15-19 who have begun childbearing rises rapidly with age, from 3 percent among women age 15 to 22 percent among women age 17 and 54 percent among women age 19. Adolescent childbearing is more common in rural than in urban areas (27 versus 19 percent, respectively). There is regional variation, with Teso sub region having the highest proportion of adolescents who have begun childbearing and Kigezi sub region having the lowest (31 and 16 percent respectively). The proportion of teenagers who have started childbearing decreases with increasing level of education: slightly more than one third of teenagers age 15-19 with no education (35 percent) have begun childbearing compared with 11 percent of those who have more than secondary education. Teenagers in the lowest wealth quintile tend to begin childbearing earlier than those in the highest quintile (34 versus 15 percent, respectively).

In Mukono CCAYEF's district of concern, it was reported by Mukono District Health Officer (DHO) that the district is among those leading in teenage pregnancy cases, He said that according to last year's district health report, 24% of all teenage girls in the district with a population of 700,000 people have produced children.

It's upon such global and national statistics that CCAYEF undertook an assessment to measure the magnitude of the problem as well as coming up with valid remedies to the same.

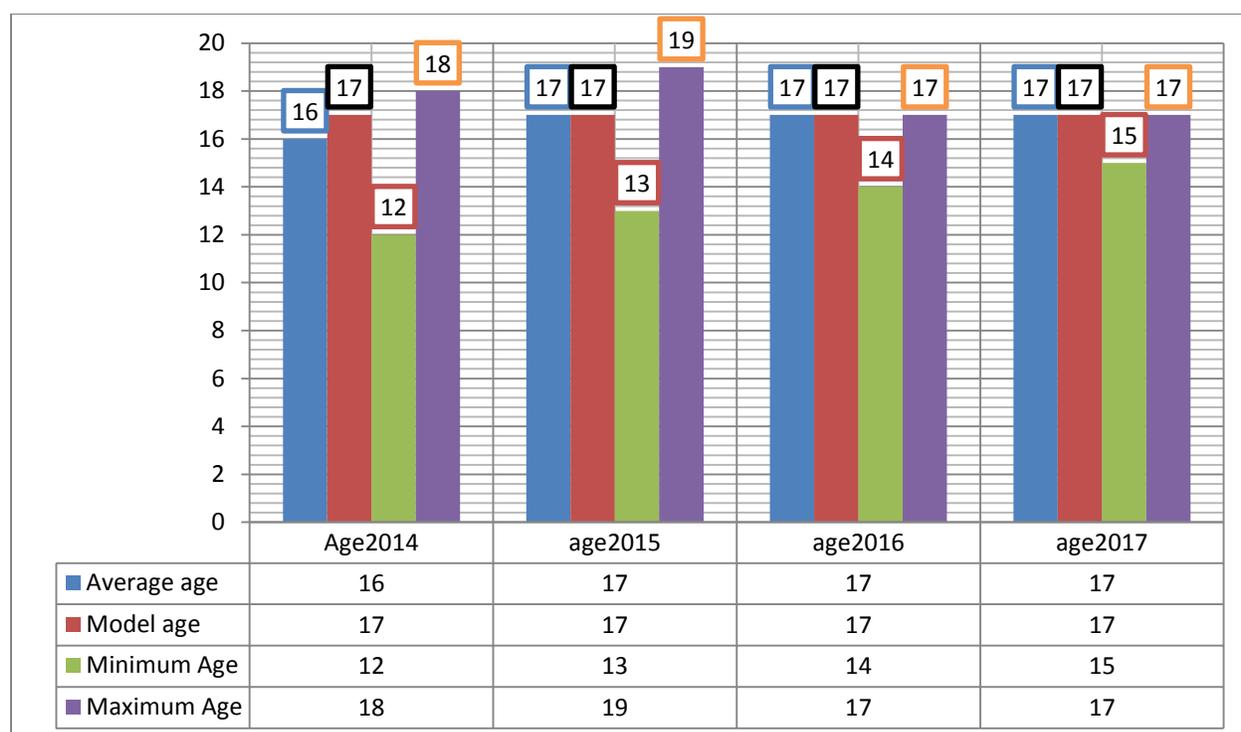
## **3.0.MAJOR FINDINGS FROM THE ASSESSMENT**

The CCAYEF teen mother assessment survey report carries information from 2014 - May 2017 and it's well detailed and tabulated in this section.

### **3.1.Personal characteristics of the teen mothers**

- i) Age pertains

Based on the results from the teen assessment tool, there is improvement in the ages of the teen mothers at first pregnancy. On average, teenage girls conceived their first pregnancy at age 16 in 2014 as opposed to 17 years in 2015, 2016 and 2017. This is a step ahead in CCAYEF’s strategy to improve on the age of first conception for teens. The results also show that among all teens that were recruited in 2015 the majority were 19years old yet for those recruited in 2016-2017; the oldest was 17 years and the youngest in all the period under review was 12 as indicated in figure 1 below:



Source: CCAYEF ASSESSMENT FORM ‘A’ 2014-2017

**i) Number of Teenage pregnancies registered per year (2014-2017)**

**Figure 2: Teenage pregnancies registered**

	Frequency	Percent
2014 Total registered	126	23.20%
2015 Total Registered	180	33.10%
2016 Total registered	212	39%
2017 May Total registered	26	4.80%

<b>Total</b>	<b>544</b>	<b>100</b>
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**ii) Teen mothers home Districts**

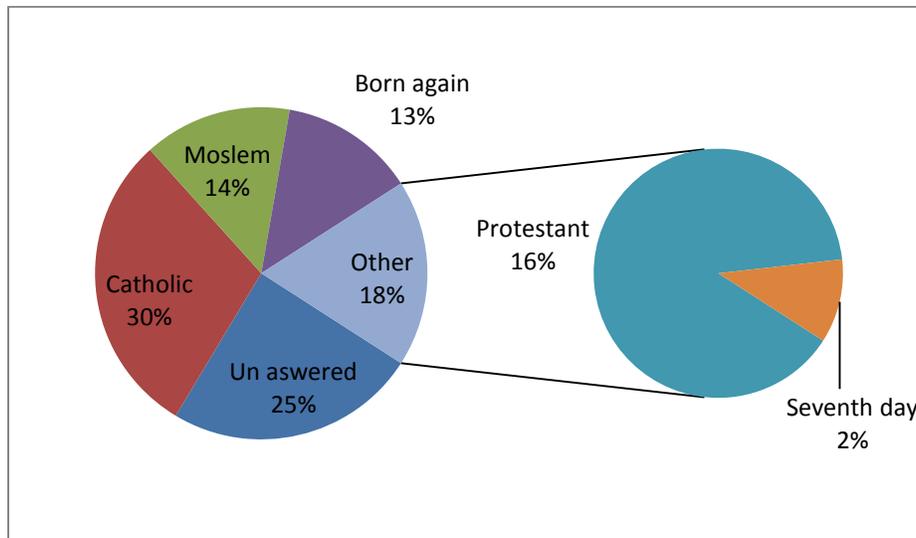
<b>Home District</b>	<b>Frequency</b>
Amurya	1
Arua	5
Bugiri	3
Buikwe	9
Bukoba-Tanzania	1
Busia	3
Butalejja	2
Gulu	1
Hoima	1
Iganga	9
Jinja	14
Kabale	1
Kampala	11
Kamuli	9
Kamwenge	1
Kapchorwa	1
Kasese	4
Kayunga	12
Kiboga	1
Luweero	6
Lyantonde	1
Manafa	2
Masaka	12
Mayuge	3
Mbarara	3
Mbale	12
Mityana	8
Mpigi	5
Mubende	7
Mukono	197
Nakaseke	1
Namutumba	1
Soroti	1
Tororo	2
Wakiso	18

**NOTE: there was need to trace the origin of the girls because, this could help us**

**iii) Religion of the teen mothers**

Results indicated 25% of the teens were not sure of their religious affiliations, nor could they mention the type of religion their guardians belong or belonged to given that in Uganda a child takes on the religion of the parents. However for the mentioned, majority of the teens reported to belong to the Catholic community (30%), Protestants/ church of Uganda (16%), only 2% of the teens reported to belong to other religious groups, as detailed in figure 2 below.

**Figure 2: Showing the religion of the teen mothers**



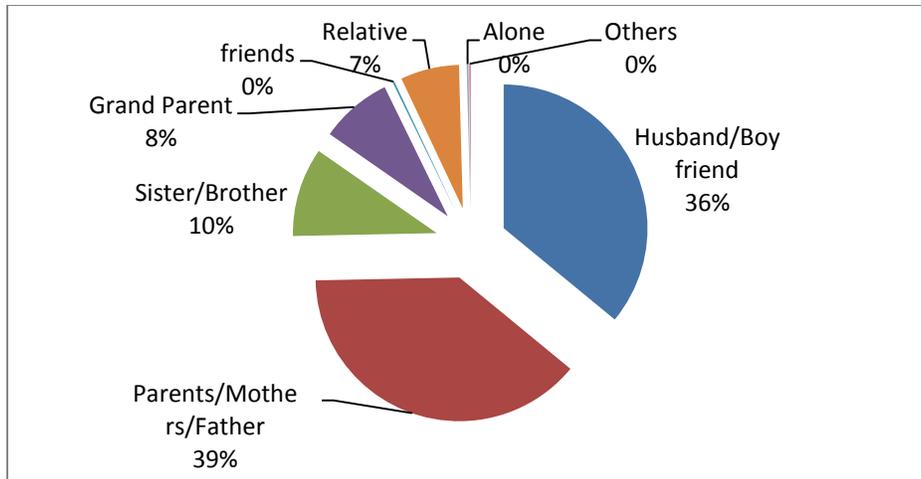
Failure to know one's religion is a hindrance to the spiritual intervention to curb teenage pregnancies.

**Source: CCAYEF TEEN MOTHER ASSESSMENT FORM 'A' 2014-2017**

**iv) Next of kin/ care taker**

Results from the assessment, identified parents and boyfriends, (39% and 36%) respectively as the most persons next of kin to the pregnant teens. However, based on these records, other persons involved in taking care of the pregnant teens includes, mothers in laws, Pastors, employers, and good Samaritans friends, as detailed in figure 3 below.

**Figure 3 showing the next of Kins**

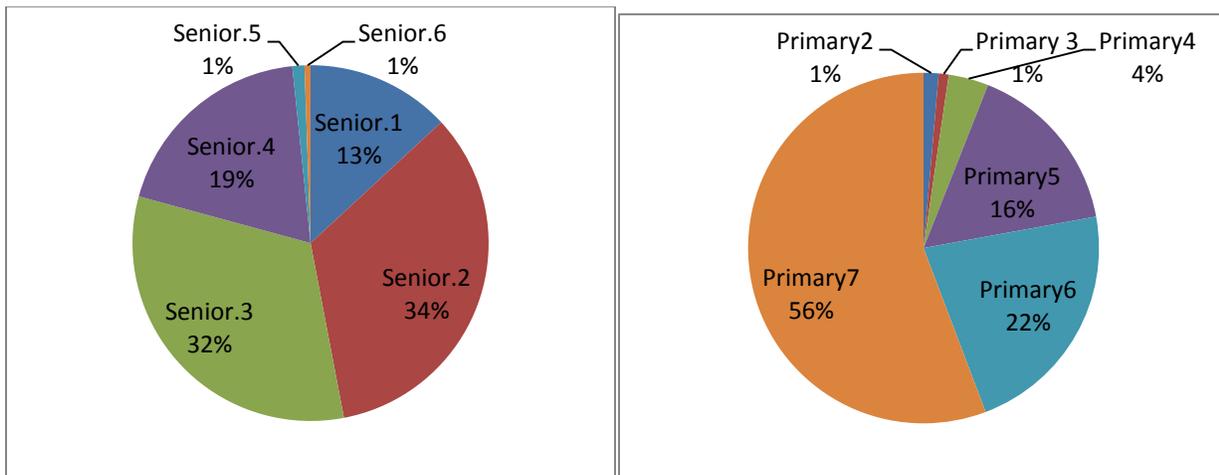


**Source: CCAYEF TEEN MOTHER ASSESSMENT FORM 'A' 2014-2017**

**v) Highest level of education of the teen at pregnancy**

Results from the assessment revealed that teens are more vulnerable to pregnancy in primary seven and primary six (56% and 22%) at primary level; and senior two and senior three (34% and 32%) respectively at secondary level as detailed in figure 4. (1-2) below:

**Figure 4 (1-2) Shows the highest level of education of the teen mothers**

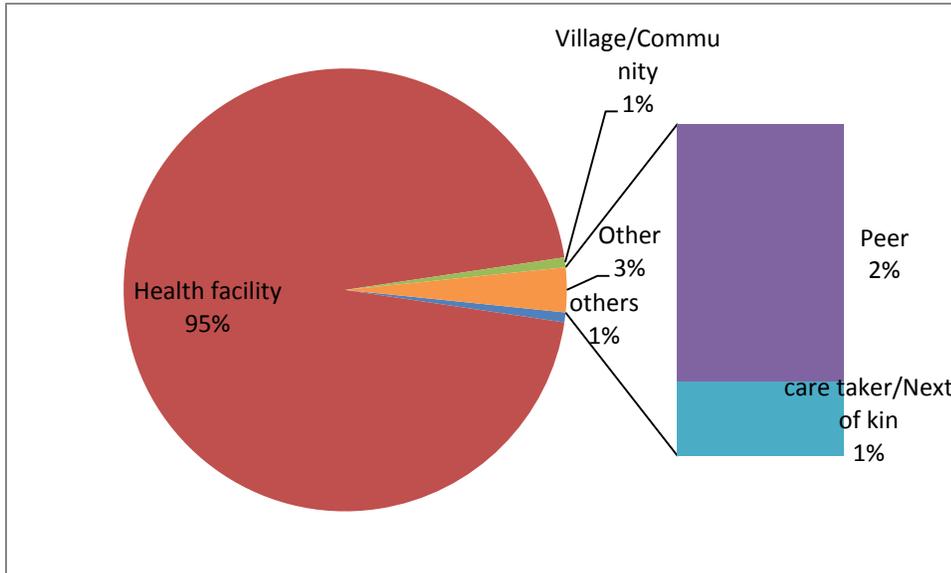


**Source: CCAYEF TEEN MOTHER VULNERABILITY ASSESSMENT FORM 'A' 2014-2017**

**vi) Referral points**

Results from the assessments indicated health facility as the pronounced referral point about teenage pregnancy (95%) and peers (2%), as detailed in figure 5 below.

**Figure 5 Shows referral points for teenage mothers**

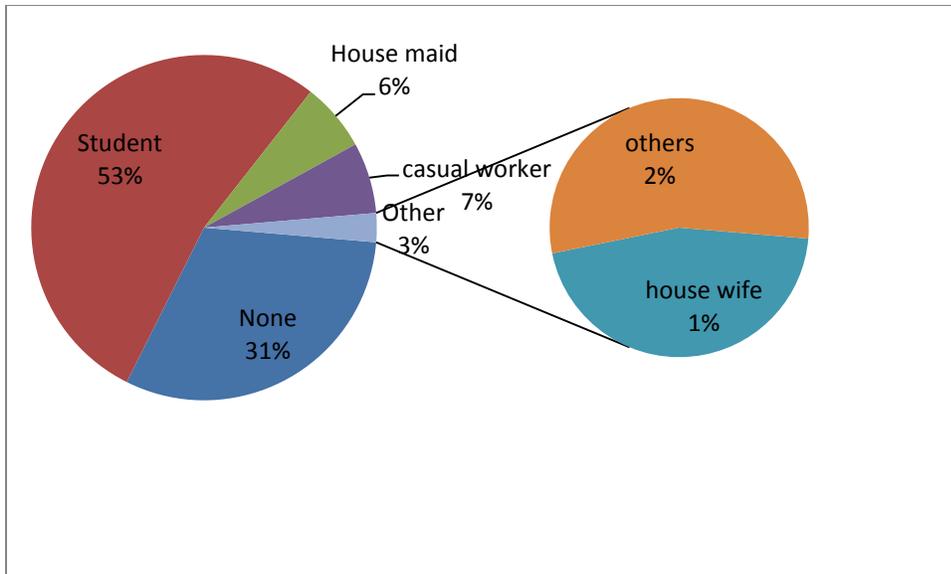


**Source: CCAYEF VULNERABILITY ASSESSMENT FORM 'A' 2014-2017**

**vii) Occupation of the teen before pregnancy**

The assessment results have indicated students (53%) and sitting home teens (31%) as the most vulnerable girl children to teen pregnancy, as detailed in Figure 6 below:

**Figure 6 showing the occupation of teen before pregnancy**



**Source: CCAYEF ASSESSMENT FORM 'A' 2014-2017**

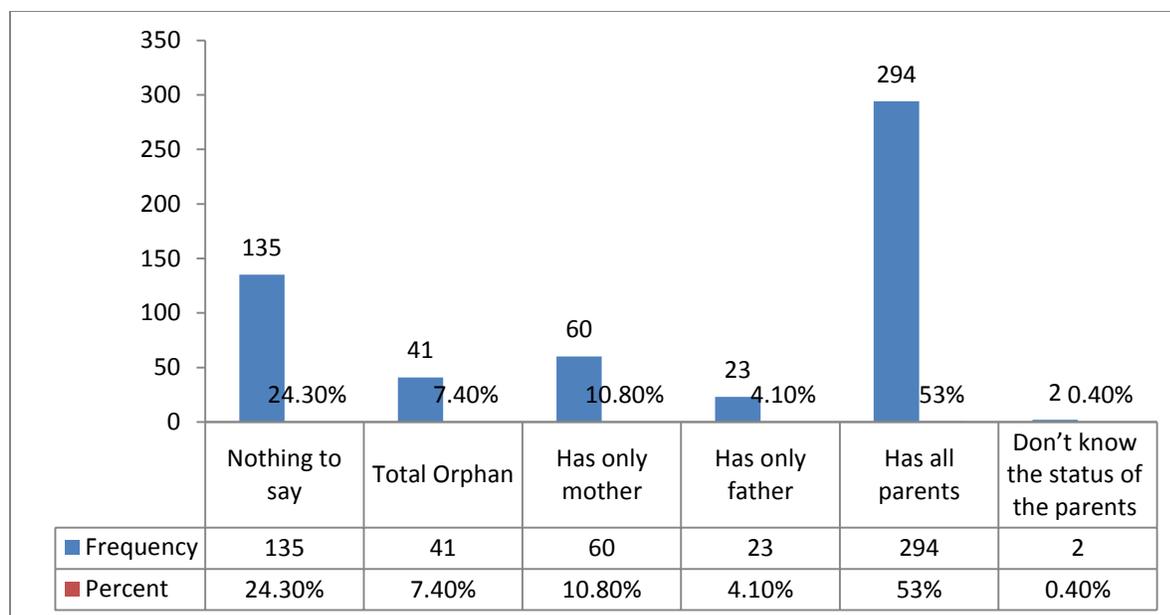
**viii) Physical and mental status of the teens**

Only 1% of the pregnant teens were reported to be disabled in the period of 2014-2017, 99% of the impregnated teens were normal teens.

**ix) Orphanage status of the teens**

Results have greatly indicated most of the teens (53%) are not orphans, (have all the parents) only 7.4% are Total orphans as indicated in figure 7 below:

**Figure 7 Shows the orphanage status of the teen mothers**



Source: CCAYEF ASSESSMENT FORM 'A' 2014-2017

## A. TEEN FAMILY HISTORY

### i) Birth order

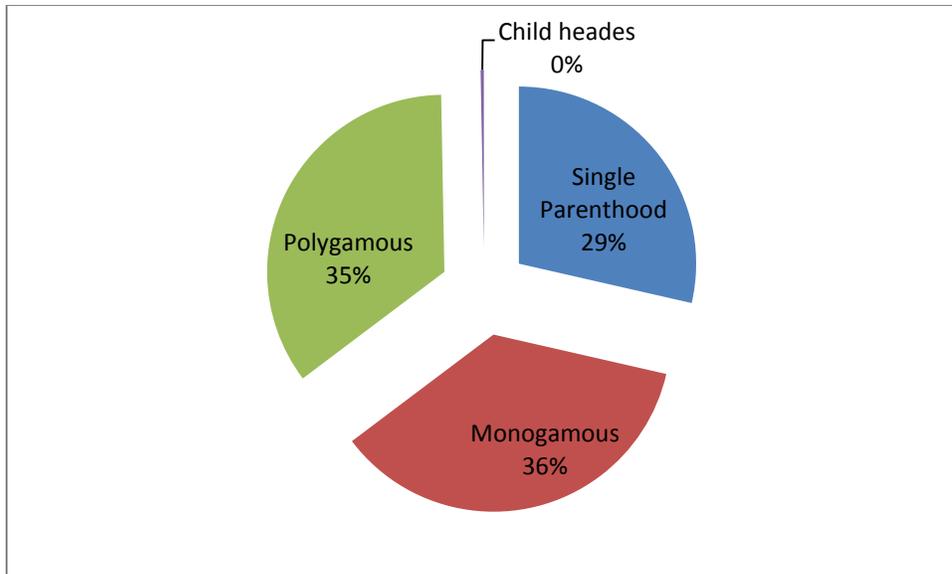
Results from the assessment reported on average, teens in birth order 4 are more vulnerable to teenage pregnancy, however majority being the firstborn's as indicated in table below.

Statistics	
Birth order:	
Average	4
Model birth order	1

### ii) Household type

Based on the results from the assessment, majority of the teen mothers (36%) are from monogamous families, only 29% of the teens reported to be from single parents as detailed in figure 8 below. It was further reported that, of the single parents, 76% are mothers; only 24% are fathers.

Figure 8 showing household type



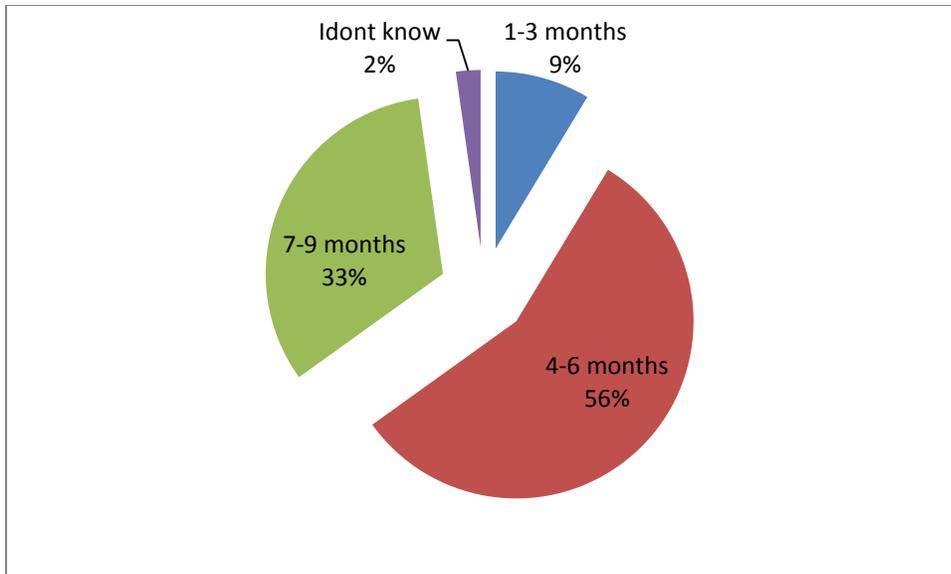
**Source: CCAYEF VULNERABILITY ASSESSMENT FORM 'A' 2014-2017**

## **B. TEEN PREGNANCY HISTORY**

### **i) Age of pregnancy at registration**

By the time of the recording, it was reported that 90% were still pregnant only 10% had already given birth. However in all the four years, most of the teens (56%) were identified with pregnancies between 4-6 months and 7-9 months (33%), only 2% could not tell how old their pregnancies were as detailed in figure 9 below.

**Figure 9 showing the duration with pregnancy**



**Source: CCAYEF ASSESSMENT FORM ‘A’ 2014-2017**

**ii) Person responsible for pregnancy**

It was reported that about 2% of the teens could not easily tell the actual names of the persons that impregnated them, while 82% could.

**iii) Age of the person responsible for pregnancy**

It was reported during the assessment that, the average age of the men responsible for impregnating teens is 22 years, with majority at age 20 years, the youngest at age 15 years and oldest at age 45 years as detailed in table below:

**Table showing age of the persons responsible for pregnancy**

Average age	22
Model age	20
Minimum age	15
Maximum age	45

iv) Occupation of the person responsible for pregnancy

Occupation					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		213	38.4	38.4	38.4
	ARTIST	2	.4	.4	38.9
	ASKARI	1	.2	.2	39.1
	BARBER	2	.4	.4	39.5
	BODABODA CYCLIST	33	2.9	2.9	45.4
	BRICKLAYER	4	.5	.5	45.9
	BROKER	1	.2	.2	46.3
	BUILDER	41	6.8	6.8	53.2
	BUSINESSMEN	45	6.3	6.3	60.5
	BUTCHER	1	.2	.2	61.4
	CARPENTER	7	1.3	1.3	62.7
	CASUAL WORKER	30	2.5	2.5	66.1
	CHAPATI MAKER	1	.2	.2	66.5
	CHARCOAL BURNER	1	.2	.2	66.7
	COBBLER	1	.2	.2	66.8
	D.J	1	.2	.2	67.6
	TAXI DRIVER	19	3.4	3.4	71.0
	ELECTRICIAN	5	.9	.9	71.9
	ENGINEER	6	1.1	1.1	73.0
	FACTORY ATTENDANT	2	.2	.2	73.2
	FARMER	18	3.2	3.2	76.6
	FISHERMAN	3	.5	.5	77.1
	HAIRDRESSER	1	.2	.2	77.3
	HARDWARE SELLER	1	.2	.2	77.5
	HOTEL ATTENDANT	1	.2	.2	77.7
	HOUSE BOY	1	.2	.2	77.8
	LAWYER	1	.2	.2	78.0
	LIBRARIAN	1	.2	.2	78.2
	LUMBERER	3	.2	.2	78.7
	MAINTAINER IN A COMPANY	1	.2	.2	78.9
	MAKES BRICKS	1	.2	.2	79.1
	MARKET/SELLS FOOD	1	.2	.2	79.3
	MECHANIC	21	3.8	3.8	83.1
	MOBILE MONEY AGENT	1	.2	.2	83.2
NOT SURE	2	.4	.4	83.6	
OWNS A RETAIL SHOP	1	.2	.2	83.8	
POLICEMAN	5	.7	.7	84.7	
SECURITY OFFICER(ASKARI)	1	.2	.2	84.9	
NEWSPAPER VENDOR	1	.2	.2	87.0	
SHOP ATTENDANT	8	1.3	1.3	88.3	
STUDENT	30	5.4	5.4	94.4	
TAXI DRIVER	8	1.3	1.3	95.9	
TEACHER	8	1.4	1.4	97.5	

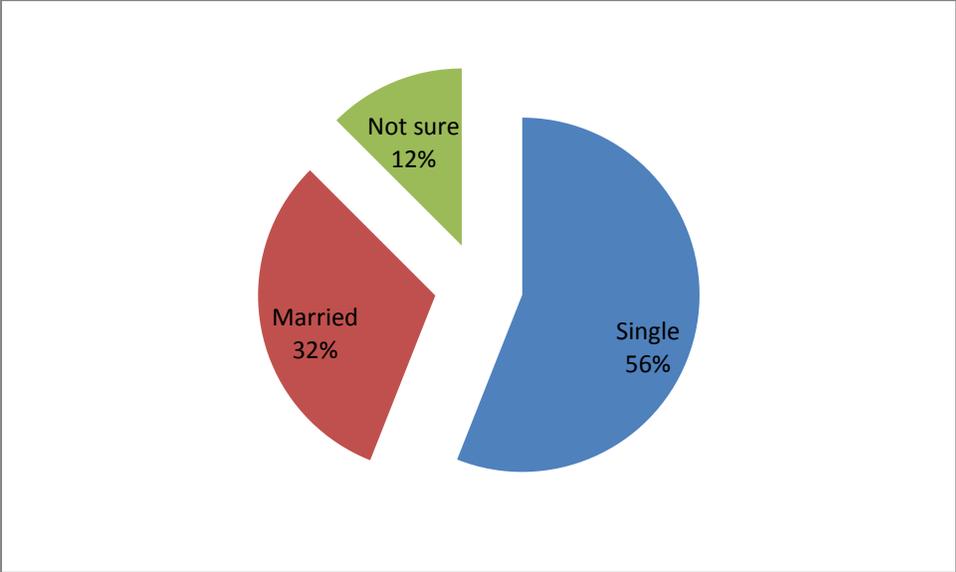
TECHICIAN	1	.2	.2	97.7
TENT MAKER	1	.2	.2	97.8
WAITER	1	.2	.2	98.0
WELDER	7	.5	.5	98.6
FACTORY WORKER	4	.4	.4	99.8
Total	555	100.0	100.0	

According to the above records, out of 555 men who impregnated teens, Business men (45) are the major culprits; followed by builders (41); Bodaboda cyclists and Students at (33); Casual laborers (30); Mechanics (21); Taxi drivers (19); and farmers (18).

**v) Marital Status of person responsible for pregnancy**

Results from the assessment revealed that only 12% of the teen mothers were not sure of the marital status of their men that impregnated them. However, 56% of the responsible men were reported as being single at the time of conception and 32% married men as detailed in figure 10 below:

**Figure 10 shows the marital Status of men responsible for teenage pregnancy**



**Source: CCAYEF VULNERABILITY ASSESSMENT FORM ‘A’ 2014-2017**

**vi) Financial support from persons responsible for pregnancy**

<b>Financial support:</b>		
	Frequency	Percent
Nothing mentioned	155	27.9
Supportive	279	50.3
Not supportive	105	18.9
Ran away	11	2.0
In prison	5	.9
Total	555	100.0

**vii) Teenage moms who liked the pregnancies they had**

<b>Do you like the pregnancy?</b>		
	Frequency	Percent
Non Response	175	31.5
Yes	308	55.5
No	72	13.0
Total	555	100.0

13% of the teenage moms did not like the pregnancies they had and some wished to have them out, while 31% gave no response when this question was put to them.

**viii) Knowledge of Family Planning methods**

Only 44% of the teen mothers reported that by the time of conception were aware of existing family planning methods, while 56% were not aware of any family planning method; and only 35% of the teens had an intension and interest of getting pregnant at the time of conception of the pregnancy.

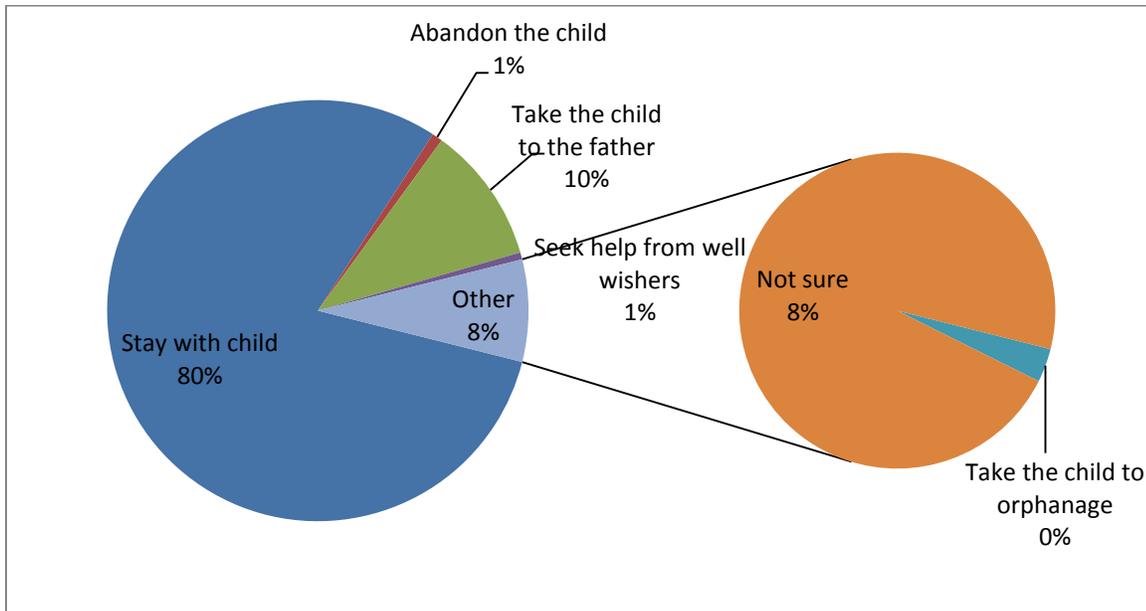
**ix) Availability of Family support to the pregnant teen**

Following the relationship between the teens and their families, 93% of the teens revealed they are in good terms with their families and the families were very supportive by the time of this assessment.

**x) Plan for taking care of the children**

80% of the teen mothers had plans and interests of staying with their children, only 1% of teens had plans of abandoning their children as detailed in figure 11 below.

**Figure 11 showing teen mothers plans for children care**



**Source: CCAYEF ASSESSMENT FORM 'A' 2014-2017**

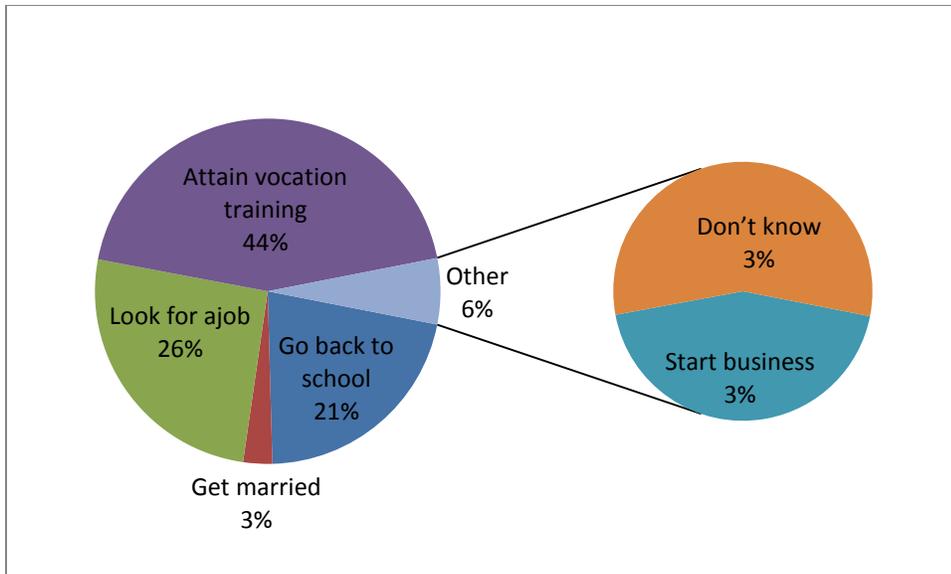
**xi) Ways through which teen mothers plan to care for their babies were;**

- ❖ Give the Baby to her Sister
- ❖ Give the Baby to her Aunt
- ❖ Her Mother Would Make the Decision
- ❖ Leave It with the Grandmother
- ❖ The Baby Will Stay With the Father
- ❖ To Leave The Child With her Relatives

**xii) Plans after Pregnancy**

Results have indicated that most of the teens (44%) are interested in vocational skills training, looking for jobs (26%) and going back to school to attain formal education, as indicated in figure 12 below:

**Figure 12: Showing teens plans after pregnancy**

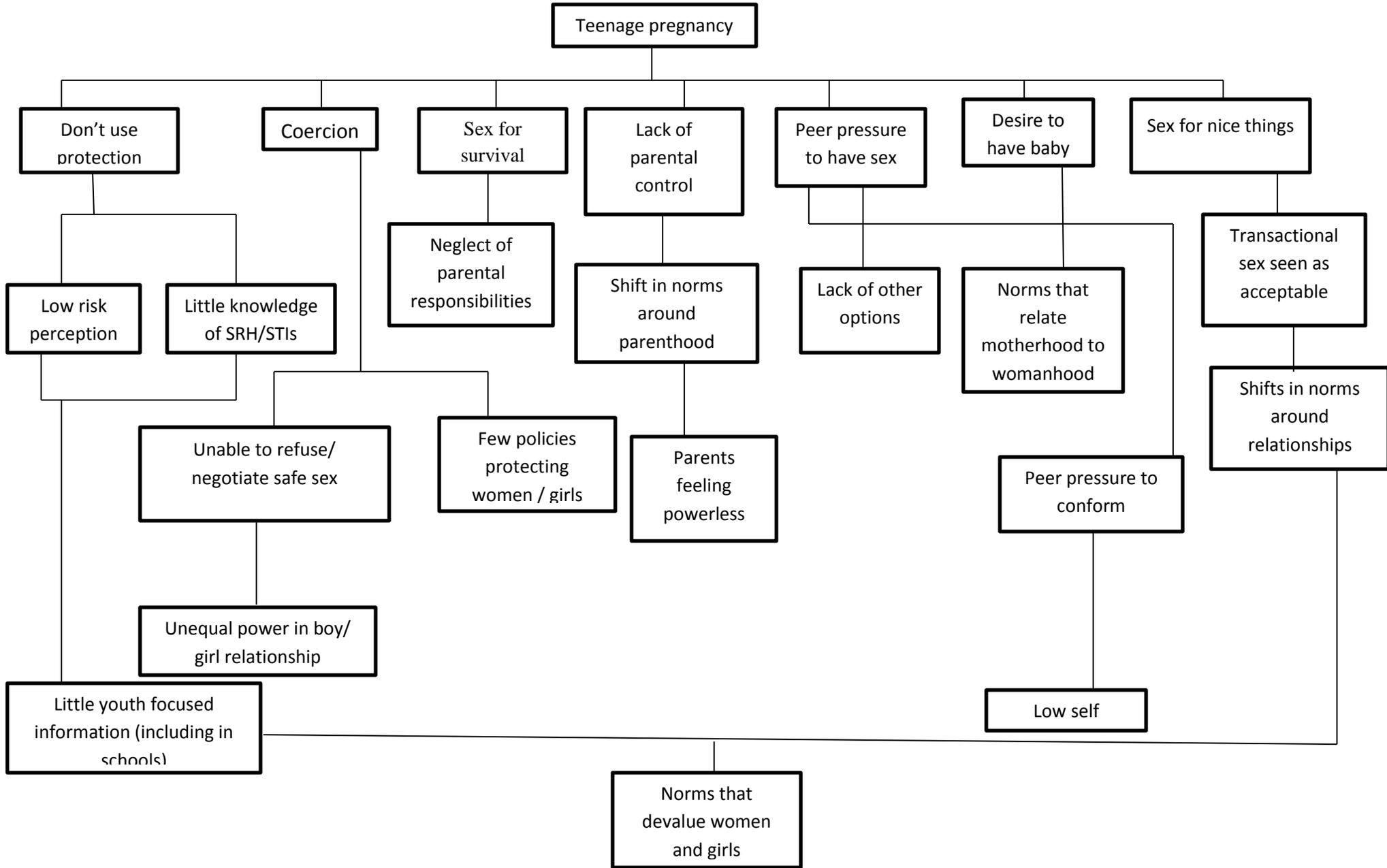


**Source: CCAYEF ASSESSMENT FORM 'A' 2014-2017**

**NOTE:**

The above statistics presents a wider view of teenage pregnancy in Mukono district, however the statistics done fully explain the cause maker of the problem in question, as well as highlighting CCAYEF's contribution in same, therefore the next part will be introducing you to the problem bottom line and CCAYEF already implemented remedies and suggested plans.

## WHY DO ADOLESCENT/ TEENAGE GIRLS GET PREGNANT: CCAYEF'S TREE ANALYSIS



A review of the tree analysis highlights the issues that appear to be more instrumental in influencing negative behaviours and in turn fosters teenage pregnancy: Norms that view transactional and intergenerational sex as acceptable, and norms that disempower women, affect the context in which relationships are formed, and affect young people's ability to protect themselves against unintended pregnancy and STIs. Norms also contribute to the creation of peer pressure as young people are increasingly expected to behave in specific ways

The tree highlighted the complex interaction of factors that contribute to teenage pregnancy. This calls for a multi-layered approach to behavior change

## **CCAYEF STRATEGIES IN REDUCING TEENAGE PREGNANCY**

When carrying out mitigation measures CCAYEF sought to answer the following questions first,

### **I. The problem or issue**

Is teenage pregnancy a problem in Mukono district? What are the consequences? Who is affected? How are they affected? Are there related issues of concern? Is this issue of a national widespread concern?

### **II. Barriers and resistance**

What key individuals or groups might oppose efforts to prevent teenage pregnancy? Can they be involved effectively? What other barriers might limit the effectiveness of the prevention initiative? How can the barriers and resistance be overcome?

### **III. Resources for change**

What resources and capacities are needed to address the mission? What local individuals or groups could contribute? What financial resources and materials are needed? Where the money and materials might be obtained?

### **IV. Solutions and alternatives**

What are some alternatives for addressing the issue or problem in light of the anticipated barriers and resources?

As per the statistics presented as carried out in Mukono district as well as the national and international statistics, it quite evident that the first question "the problem or issue" is well answered. Therefore CCAYEF suggests "solutions and alternatives" as follows

## TEENAGE MOTHER REDUCTION STRATEGIES

Based on the tree analysis described above, the following section proposes key information and messages for each of the issue identified. The reduction strategies should be around puberty, self, esteem, growing up and abstinence and delaying the start of sexual intercourse.

Audience	Girls 12-19				
Behavioural communication objective	Key information	Barriers	facilitators	Key benefit	Key messages
<p>By 2020, girls aged 12 to 19 years will:</p> <p><b>Feel confident</b> about postponing sexual debut and refusing sex till older and ready.</p> <p><b>Understand</b> that nobody has the right to touch them against their will and know what to do should they feel violated.</p> <p><b>Feel confident</b> about their potential as successful women and be empowered by their personal and collective strength to say no to sex or sex without a</p>	<p><b>Pregnancy</b> at younger age is dangerous to a girl’s growing body. Even if she has gone through menstruation, she should wait till she is more than 18 years and be a healthy, happy mother.</p> <p><b>You</b> have the right to refuse sex, and nobody should touch you against your will. If someone does, you</p>	<p><b>Little</b> accessible information on sexual health and rights.</p> <p><b>Information/materials</b> not tailored to younger adolescents.</p> <p><b>GBV</b> referral protocol is not well implemented</p> <p><b>Conflicting</b> policies, with sex under 18 being criminalized.</p> <p><b>Poor</b> adult-child</p>	<p><b>CCAYEF</b> team</p>	<p><b>Communicate</b> “no” demands respect by a boy, This helps you distinguish who is worth dating. Health benefits of not becoming pregnant and not engaging in sexual activity at a young age. More time to work towards your</p>	<p>illustrative slogans</p> <p>The future belongs to us!”</p> <p>Suggested tagline: “We are/ I am proud to wait”</p> <p>Girl saying “I am not ready in my body and mind to be a mother. I still want my childhood!</p> <p>I am proud to wait till after I am 18”</p> <p>How do you want to</p>

<p>condom. <b>Have the skills</b> to make informed decisions about not engaging in sexual activity until</p> <p><b>Know that going through menstruation</b> is not a reason to become sexually active.</p> <p><b>Have information and skills to abstain from sex</b> and avoid risky behaviours and seek help when needed should they choose to engage in</p>	<p>should tell a caregiver of trust.</p> <p>If someone starts touching you in a way you don't like, stop them immediately, even if they tell you they mean no harm or it's a joke. Do so every time. Be firm.</p> <p>Every girl is beautiful. Strong inside equals' beauty outside. Be strong and say no to sex till you're older and ready.</p> <p>Abstaining from sex until you are older and ready will help you focus on your dreams and goals, and will spare you a lot of</p>	<p>communication.</p> <p>Culture of silence around sexual violence. Limited communication channels available, especially in rural areas. Sex often motivated by material gains at times cater for basic needs</p> <p>Lower status of girls makes younger adolescent females particularly vulnerable. Social pressure to conform to a certain way of dress, own a mobile phone, etc. Links between</p>		<p>goals. Stay in school and have a career.</p> <p>Stay young and beautiful longer</p>	<p>spend your mornings? Abstain from sex (image of girl going to school and pregnant girl vomiting with morning sickness). Our bodies are for us. We are not ready for sex.</p> <p>Being strong inside makes you beautiful outside.</p> <p>Say no to sex. It's cool to wait.</p> <p>Delay sex for a brighter future.</p> <p>We are still girls so let us be.</p>
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	<p>worry.</p> <p>Abstaining from sex is the safest way to avoid pregnancy.</p> <p>No one can force you to have sex. Only YOU can decide. If you choose to have sex, you can get pregnant or infected with a disease, even if it is the first time. The only protection is abstaining from sexual activities, and if not using a condom every time you have sex.</p> <p>Having a baby at your age will bring further problems in your, it will prevent you from enjoying your youth</p>	<p>menstruation initiation and readiness for sex.</p>			
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	and fulfilling your potential				
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## **OTHER MITIGATION METHODS**

**Provision and sensitization in various contraceptive techniques;** another strategy that is being proposed by CCAYEF according to the assessment is sensitizing teenagers in various contraceptive techniques. Although abstinence remains the best way to prevent pregnancy among teens, it is a fact that there are still a large number of them who will be involved in sexual relations. For this reason, it is important that teens be provided with broad information on how to do so responsibly using various contraceptive techniques. Most of the sex education in communities consists of one message: "Don't have sex--but if you do, use a condom" The problem that rises from this is that teenagers are not being exposed to extensive information on the various forms of birth control, condoms, and other methods of prevention that are available. Contraceptives are talked about in sex education classes, but only as being ineffective in preventing pregnancy and also, these classes on contraceptives should include information on how to obtain the different methods of birth control. CCAYEF advocates for "TEENAGE BASED HEALTH CLINICS" nationwide with the purpose of reducing teen pregnancy with the availability of contraceptives. This is a way to ensure contraceptive use for many young teens that, rather than going to their parents for help in obtaining birth control, choose to have sex without protection simply because that protection is not made available to them. In this CCAYEF estimates that it will reduce teenage pregnancy from 39% registered in 2016 to 20 % by 2020.

**Focus group discussions; consequences of teenage pregnancy,** CCAYEF according to its assessment the real consequences of having a child at such a young age are unknown to teenagers. Teens need to be aware of the harsh reality of raising a baby and the negative effects that an unplanned pregnancy can cause in both the mother and the child's lives the effects of having a child out of wedlock at a very young age ; Lowered health for newborns and increased risk of early infant death; Retarded cognitive, especially verbal, development; Lowered educational achievement; Lowered job attainment: Increased behavior problems; Lowered impulse control; Warped social development; Increased Welfare dependency" . Teenage mothers must be aware of the tremendous effect their offspring will have on society in the future, and the high risk of the cycle repeating once this child becomes a teen. Teens must also be aware of the fact that an unplanned pregnancy will take a toll on other aspects of their lives. When exposed to

such information about the results of an unplanned pregnancy, teens are forced to analyze whether sex is worth the risk of forever changing their lives, and those of their future children.

**Men (culprit involvement),** CCAYEF strongly believes that the involvement of men who are culprits into the teenage pregnancy prevention strategy could be a great move towards solving the latter, according to the assessment business men, builders, bodaboda cyclists, students are the major culprits when it comes to impregnating teens. Therefore as focus group discussions go on among teen girls the same should be to the men, however since men don't involve much in community social affairs, the appropriate tool to use is sports and religious places. Sports activities liked by men should be organized and sensitization is done at the end of every activity were the gospel of teenage pregnancy is preached.

#### **Key partners in the strategy implementation process**

Community

Uganda police

CSO's

Government

departments

and

agencies

