# Teenage Pregnancy Prevention Evaluation Report


Child Care and Youth Empowerment Foundation

Mukono, Uganda (2014-2016)

## 1.0 Background

Over one million pupils who enrolled for Primary One under the Universal Primary Education (UPE) in 2006 did not reach Primary Seven.This indicates a whopping 71% drop-out rate, much higher than the 40% usually quoted.According to statistics from the Ministry Of Education, 1,598,636 pupils enrolled for Primary one in 2006.

But the Uganda National Examinations Board (UNEB) figures for pupils who sat Primary Leaving Examinations (PLE) 463,332, which is only 29% of those who enrolled in 2006.

In East Africa, Uganda has the lowest proportion of children staying in school up to P7, according to a 2010 report by the UN Educational, Scientific and Cultural Organisation (UNESCO).

Similarly, the burden of Sexual Reproductive ill-health is high among young people in Uganda, where the median age of sexual debut is 16.7 years with teenage pregnancy rate among girls aged 15-19 years at 24 percent. The adolescent birth rate stands at 159 per 1,000 births (UDHS, 2011). Given the vulnerabilities associated with early pregnancy, maternal death among young women 15-24 years of age makes a large contribution the overall maternal mortality ratio in Uganda. This is partly contributed to unsafe abortion. Further, adolescent pregnancy contributes to 30 per cent to the primary school drop-out ratio (AODI/UNICEF study (2011). To ensure that young people can make own, informed and healthy choices regarding their sexual and reproductive health, interventions on sexual and reproductive health and rights (SRHR) education for young people need to be effective and thus be based on the well-known quality criteria.

Mounting concerns over the risks of teen sexual activity have spurred the creation of a broad range of program approaches to reducing high rates of teen pregnancy and STDs among Uganda adolescents. The range of existing program strategies reflects the complexity of the issue and the varying needs of diverse target populations, as well as differing stakeholder opinions about the most appropriate strategy. Abstinence education programs focus on delaying sexual initiation, and many of these programs focus specifically on delaying sexual activity until marriage. By contrast, comprehensive sex education approaches generally include information on both the benefits of abstinence and risk mitigation through condom and contraceptive use for sexually active adolescents. Youth development approaches often combine elements of either abstinence or comprehensive sex education approaches with broader services, such as mentoring, health services, or case management. Some of these varied program models target widely defined populations in diverse settings, while others were developed to meet the needs of specific high-risk populations. Many adolescent pregnancy prevention programs continue to be based in schools, but increasingly programs are also delivered in community, clinic, and home settings.

CCAYEF rolled out am ambitious program 2014-2019 to reduce Teenage pregnancy among adolescents in Mukono District. There is a need for pragmatic steps to be taken to address the challenge of teenage pregnancy from 24% to atleast 20% by December

2019 under the SIC program. Under the campaign, girls are encouraged to stay in schools and abstain from sex until they are old enough (18+)

### 1.1.0 Overview of the Program Evaluation

Early and unintended pregnancy is a major public health issue. This is particularly the case in sub-Saharan Africa (SSA), where adolescent girls experience the highest rates of pregnancy in the world.1 A high proportion of pregnancies among adolescent girls aged 15-19 years in SSA are unintended, ranging from 39% in Tanzania to 59% in Kenya and 24% in Uganda (2011 DHS)
.

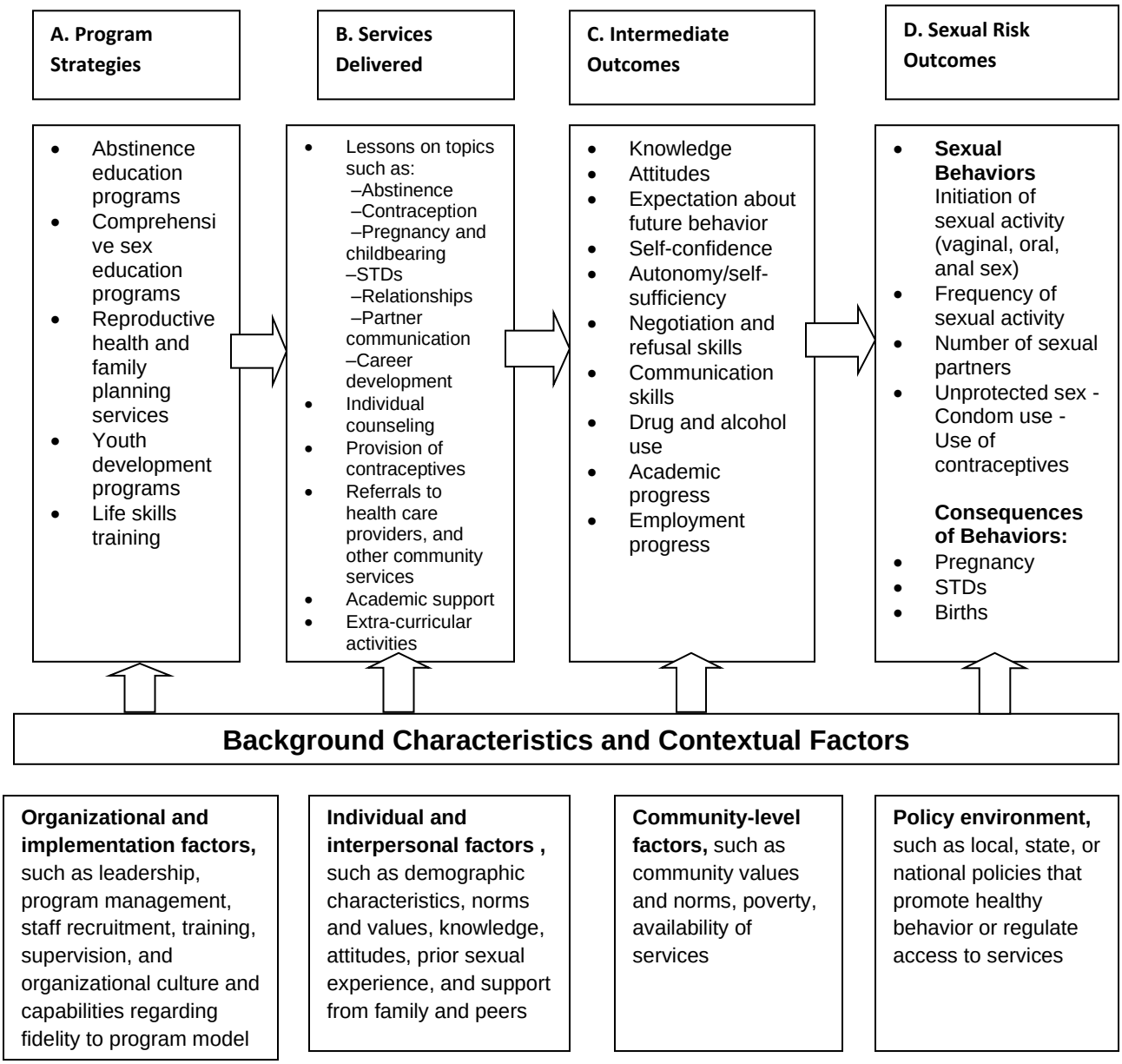
Adolescent sexual activity and its consequences continue to be important policy concerns in the Uganda, Mukono in particular. Nationwide, nearly half of all high school students report having had sex and one-fifth report having had four or more partners by the time they graduate (Centers for Disease Control and Prevention (UDHS, 2011). In 2013, almost 40 percent of sexually active high school students in Mukono district did not use a condom during their last sexual intercourse, and 12 percent did not use any method of contraception (Youth Risky Behavioral Survey 2014). Such sexual risk behaviors place adolescents at risk for unintended pregnancy and sexually transmitted diseases (STDs). These and related social and economic consequences of teen sexual behaviors can be detrimental to teens, their families, their communities, and society as a whole.

The Evaluation of Adolescent Pregnancy Prevention Approaches (PPA) under the SIC program is a response to persistent concerns about the consequences of teen sexual activity. The PPA evaluation is being undertaken to expand available evidence on effective ways to prevent and reduce pregnancy and related sexual risk behaviors among teens in the Mukono district and Uganda at large.

### 1.1.1 Selection and Description of the Evaluation Sites

A conceptual framework has guided decisions on the design of the program evaluation (Figure I.1). The framework illustrates the process by which teen pregnancy prevention approaches might affect sexual risk behaviors and related outcomes.
Pregnancy prevention programs take place in diverse and dynamic environments. The implementing organization and system, individual characteristics of youth, familial and peer support systems, community norms and resources, and policy-related factors all influence the development and selection of teen pregnancy prevention approaches, the specific services provided under each program, and how services are delivered. Individual-, community-, and policy-level factors also influence prior sexual behaviors and the availability of and access to existing services, as well as participation in teen pregnancy prevention programs and subsequent behavioral choices and outcomes.

## Figure I.1. Conceptual Framework Guiding the PPA Evaluation




The School in Charge program (SIC) (Column A of Figure I.1) aim to change, enhance, or supplement existing services and support that youth receive in their communities. Programs often provide information on health, relationship, and sex education topics, and may also address related social and behavioral issues, including life skills development, SRH, access to accurate information and other health services, academic performance, and employment opportunities (Column B). Receipt of these additional services is hypothesized to have favorable impacts on intermediate outcomes (Column C) that may serve as mediators of sexual risk behaviors and their consequences. For example, youth in Schools in Charge program might increase their knowledge about sexual behavior risks, develop more positive views on abstinence and delaying sexual debut &pregnancy, improve their communication skills and relationship quality, resist

pressure from their peers, reduce consumption of drugs and alcohol, or improve their academic performance. Through these and other changes, programs aim to affect sexual risk behaviors and, in turn, the incidence of pregnancy and STDs.

The evaluation focused largely on measuring the impacts of the program on the sexual risk outcomes shown in Column D of Figure I.1. However, as part of the impact analysis, we also measured several intermediate outcomes that the programs under study was hypothesized to affect.

### 1.1.2 Characteristics Associated with Adolescent Childbearing.

Numerous individual, family, and community characteristics have been linked to adolescent childbearing. For example, adolescents who are enrolled in school and engaged in learning (including participating in after-school activities, having positive attitudes toward school, and performing well educationally) are less likely than other adolescents to have or to father a baby. At the family level, adolescents with mothers who gave birth as teens and/or whose mothers have only a high school degree are more likely to have a baby before age 20 than are teens whose mothers were older at their birth or who attended at least some college. In addition, having lived with both biological parents at age 14 is associated with a lower risk of a teen birth. At the community level, adolescents who live in wealthier neighborhoods with strong levels of employment are less likely to have or to father a baby than are adolescents in neighborhoods in which income and employment opportunities are more limited.

## 2.0 The school in Charge program and how it works.

This program was first introduced to secondary schools of Mukono District in January 2014 starting with four schools and currently being implemented in 11 secondary schools with a broader goal of ***"Enhancing Adolescent Sexual and Reproductive Health services in secondary schools in Mukono District to improve on young people's Sexual Reproductive Health behaviors, attitudes and knowledge by December 2019."***The program address issues of young people's reproductive health demands through advocacy and lobbying for scale up, support and promotion of sexuality education in schools and communities, provision of Life skill based education and behavior change communication programs for young people.

## 2.1 METHODLOGY EMPLOYED BY CCAYEF IN THE IMPLEMENTATION OF THE PROGRAM

CCAYEF uses a participatory approach which involves all key stake holders while implementing the SIC program for effective and efficient provision of information and services to young people. It works with 4 secondary schools each year from Mukono municipal council which are selected randomly and introduced to life skill and sex education curriculum.

Through the District Education Office an introductory letter from the DEO is addressed to various school administrators informing them about the program and its core

objectives. The organization then organizes a buy in inception meeting with respective head teachers who have shown interest in the program to orient them about the program, level their expectation as well as showing them their roles and responsibilities throughout the program life.

Through the School Management Committee (SMCs), CCAYEF conducts 2 days training for teachers selected from respective schools in basic counseling skills, life skills, Adolescent Sexual Reproductive Health (ASRH) to build their capacity in working with adolescents as well as gaining skills in handling issues of double standards.

Upon accomplishment of the teacher training, a contact person referred to as “club patron” for each of the school health club is identified(SHC) and given training manuals and assignments to implement in school so as to ensure continued support to the club while conducting peer-to-peer programs and dissemination of information in the school environment.

CCAYEF through the SMCs and teachers, it works with SHC comprising of 25- 35 members both boys and girls who are randomly selected from all classes to be trained as peer facilitators/educators in issues pertaining to health say HIV/AIDs, effects of drugs, training in basic counseling skills, roles and qualities of a good peer educator, training in life skills e.t.c all aimed at empowering them pass on rightful information to their peers. This is done through role-plays, team building activities, discussions, creative thinking and writing, and the sharing of personal experiences. These clubs usually meet twice a month for lessons as well as sharing experiences from the club and to discuss about the effective strategies that have been employed/need to be employed to disseminate information.
Before any intervention however, a pre- test study is conducted on both the club members and the non- club members to assess their level of understanding on teenage pregnancy, HIV/AIDs and other sexual reproductive health related issues to be able to identify the gaps that need to be addressed as well as assessing the impact of the intervention at the end of the program.

IEC Materials in form of fliers and posters with information on ASRH and other health issues are also designed and distributed to the peer educators to use while disseminating information.

Continuous monitoring and support supervision is also done by CCAYEF staff to the SHC,teachers, and school administrators to ensure that activities and objectives of the program are realized.

Close to the end of the year, a Wrap-up meeting is conducted where all Peer Health Club members from all 4 current school clubs and leaders from the pioneer clubs get together with the Club patrons to plan and share best practices in their respective schools.

## 3.0 MATERIALS AND METHODS

The research questions and the outcomes of greatest interest build on the overall evaluation goals and design of the program in reducing teenage pregnancy and enhancing ASRH among young people.

The study was conducted to track record of success stories so far reached at in a period of 3 years in addressing/ reducing the incidence of teenage pregnancies in Mukono Municipality and other SRH related issues. It was conducted in a township located in the heart of Uganda, Mukono district, Mukono Municipality schools where CCAYEF interventions are being implemented. The strategy for the study was exploratory while the research design was qualitative.

The target populations were adolescents (students), teachers, and school administrators in the intervention area. The sample size was determined by saturation of data, which was achieved when 13 participants (teachers) had been interviewed

Data gathering was through questioners given to n=505 students and semi-structured interviews. Prior to any questionnaire and interview, each participant's rights were explained and informed consent was obtained. To guarantee privacy, the interviews were conducted in a private room with only the participant and the researcher present. Several data was also gathered from the three major health centers in Mukono Municipality I.e. Mukono Church of Uganda Hospital, Mukono Health center IV, and Goma Health center III, tracking the number of pregnancy cases recorded by the minors.

### 3.1.0 Measuring Program Impacts

Impacts of the SICprogram were analyzed based on data collected approximately 2 and 4 months after the end of the program curriculum, or about 7 and 10 months after youth complete the baseline survey.Given the random selection of samples, unbiased impact estimates were obtained by simply comparing pre and post-intervention outcomes.

### 3.1.1 Data

The data for the impact analysis was collected through end line surveys. These include paper-and-pencil questionnaire, which was administered to every school at the end of the year. These end line surveys were administered and overseen by a trained staff, who monitored the data collection and be responsible for distributing the questionnaires and gathering them upon completion.

### 3.1.2 Sample Description

The School in Charge program evaluation was completed in 11 secondary schools located in Mukono District, Uganda between January 2014 and September 2016. Of these schools, 7 were private and 4 were public/government. There were a total of 505 participants/ students and 13 teachers/ school administrators with 41% (n=207) being male and 59% (n=298) being female. The average age of participants was 16.2 with a

range from 12-20 years. The most common age was 15 (n=154, 17%). No other descriptive data were collected.

### 3.1.2 Outcome Measures

Drawing on the survey data, the study team constructed, and estimatedthe SIC program impacts for, a range of outcome measures. These measures fall into two broad types: (1) sexual risk outcomes, which include both measures of SRH behavior and consequences of this behavior, most notably pregnancy; and (2) intermediate outcomes, which correspond to the mediating factors through which the program would most likely impact behavior and life skills.

## 4.0 Aim and objectives

The findings will help to understand the social and individual factors associated with variations in SRH knowledge, attitudes and practices among the young people in Mukono Municipality. The study also aimed at establishing the contribution of CCAYEF intervention under the Schools In Charge Program on reducing Teenage Pregnancy in Mukono Municipality. These findings will be helpful in shaping the programming but developing more effective responses.

### 4.1.0 Specific objectives of the Survey

I. To assess the ASRH knowledge levels among adolescents in Mukono Municipality.

II. To assess the effectiveness of the program in regard to reducing the incidence of teenage pregnancy among adolescents of Mukono Municipality.

III. To understand the levels of Life skills possessed by the young people

IV. To assess the influence that tend to exert pressure to the young people

### 4.1.1 Findings

The findings discussed below were structured by the Institutions and then the age brackets. The findings suggest that, overall; the Schools in Charge program seem to have contributed to the reduction of pregnancies among teenagers of Mukono Municipality and to have enhanced the SRH knowledge and attitudes of adolescent boys and girls.

### 5.1.0 SRHR Interventions

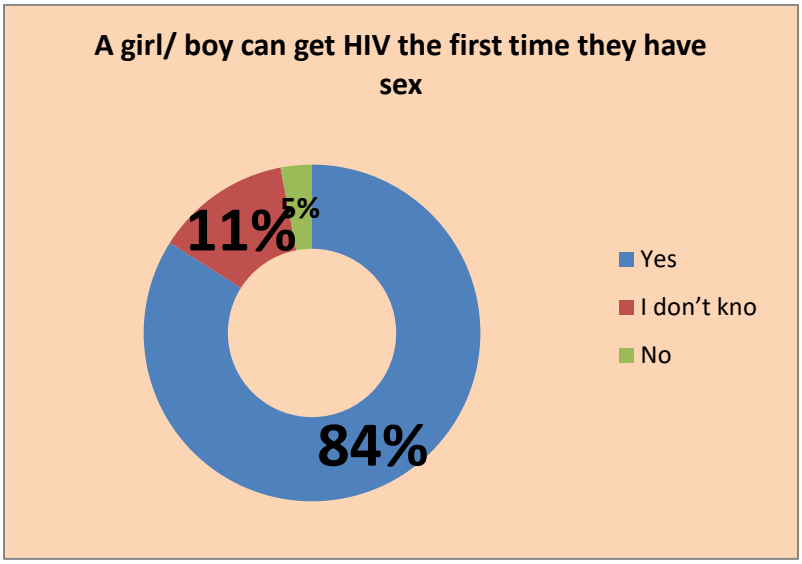
For the past 4 years CCAYEF has been working with school administrators, teachers, parents and young people across the secondary schools in enhancing their SRH knowledge and attitude with a view of reducing the challenge of Teenage pregnancy and improving the SRH knowledge, attitudes and behaviors among young people. With good partnership enjoyed with School Administrations, CCAYEF has been able to reach over 10.000 young people in Secondary schools through regular programs designed to address specific behavioral and or SRH needs.

### 5.1.1 HIV and other SRH knowledge

According to the AIC 2011, HIV prevalence among all young people 15-24 years of age was at 3.7 per cent; among young women 15-17 years, it was at 1.7% increasing sharply to 5.1% among those aged 18-19 years and to 7.1% among those aged 20-22 years with a peak of 9.6% among young women aged 22 years. (UNFPA report)

In 2014 before CCAYEF intervention, data from the Pre-test evaluation indicated that only 51% of the young people had accurate knowledge on HIV/ AIDS. From the post test evaluation study result after our intervention, it was found out that, up to n=374 (74%) of the young people have accurate information regarding HIV/ Aids. It further reveals that 87% (n=439) believes that one cannot tell by looking that another person has a HIV/ sexually transmitted infection, while only 13% (n=66) did not know. Another 84% (n=424) were aware that even for the first sexual contact one can get HIV, 56 (11%) don't know, while 5% (n=25) still believes that you can't get HIV on the first sexual contact. When explored further, from the 5% (n=25) who argued that you can't get HIV on the first sexual contact, 80% (n=20) believes that chances are much more higher only among those who play sex regularly. When the young people were asked about the options for protection against HIV transmission up to 79% (n=399) could identify at most 3 out of the 5 correct answers as opposed to 30% (n=152) before the program inception.

*Figure 1: Knowledge of HIV transmission for first sex*




The study further reveals that, 79% (n=399) of the total respondents recognize the role of the condom is preventing pregnancy, HIV and other STIs. However, a significant proportion 11% (n=56) think by bathing immediately after sex one can avert a potential pregnancy, and a STI. A little over half 68% (n=343) of the students talked to said they knew where to get Sexual and reproductive health services in their communities. A large proportion 75% (n=379) acknowledged that HIV is a personal threat to them.

### 5.1.2 SRH Attitudes and risk perception.

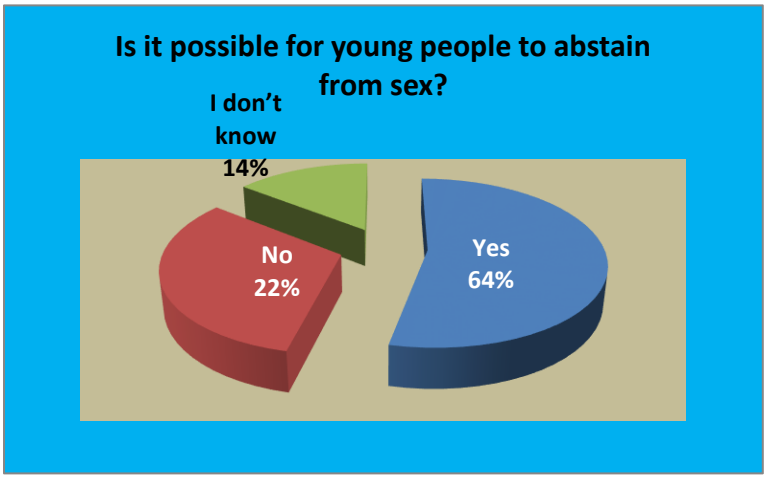
From the findings, these indicators above point to prevalence ofsafe sexual behaviors and practices among young people as well as increased access to SRH and HIV information and services. The study also sought to understand the attitudes and perceptions of the young people in regard to the risk of getting an STI.

A little over half of the respondents 338 (67%) acknowledged that they are likely to get HIV if they had unprotected sex while the rest were 18% (n=91) disagreed with this fact and 15% (n=76) did not know. This revealed a significant increase in awareness from the 49% who could acknowledge a risk from un protected sex from the pre-test evaluations.

*Figure 2: Perceptions of ability to abstain from sex.*

A insignificant (64%) proportion of the respondents expressed positive sentiments in regard to abstinence from sex. However from further analysis of the data, about 10% of these (64%) did not believe that it is possible for young people to abstain from sex if they have partners/ boy lovers.

Most (75%) students believe that HIV AIDS is a big problem in their community. However, 67% of these believe they are likely to get HIV if they have unprotected sex.




In the same group a little over a third n=182 (36%) believe they are at risk of getting HIV if they are involved in alcohol and drug abuse while another little over a third n=172 (34%) do not recognize any related risk and a further 30% (n=152) don't know.

## 5.2 Early pregnancies

"Uganda ranks among the top 10 countries with high maternal, newborn and child mortality rates despite attempts in improving health of children, adolescents, women and men in the country.The health ministry's HIV/AIDS report of 2011 showed that children are exposed to sex very early. About 71% of teenagers have risky sex, yet, according to the report, less than half use condoms.

The earlier 2006 Uganda demographic and Health Survey (UDHS) put the teenage pregnancy rate at 25%. Data from the education ministry shows that dropouts are highest among girls than boys due to early pregnancies.

The post test study analysis revealed that over half (62%) of the students felt is permissible for agirl to refuse to have sex with her boyfriend. A further desegregation and analysis of the data revealed that almost 18% of the girls felt a girl cannot refuse to have sex with her boy friend, while 20% were not very sure. They were also asked whether there could be a boy girl friend relationship without sex and 76% of the girls compared to 64% of the boys felt such relationships are a possibility.

**In terms of knowledge on ways to avoid pregnancy, majorityof the participants**

**had knowledge of contraceptives compared to previously before the intervention although some, especially the male participants (3 in every 7) had inadequate knowledge.**

The study after intervention also revealed that, there was a considerable reduction in the number of pregnancies from adolescents reported in the 3 major health centers of Mukono Municipality. This is manifested in the figure below.

**TOTAL NUMBER OF DELIVERIES FROM THE 3 HEALTH CENTRES FOR THE FINANCIAL YEARS; 2010/2011; 2011/2012; 2012/2013; 2013/2014; AND 2014/2015**

| Financial Year | Total Deliveries | Deliveries to > 18 | % | Deliveries to < 18 | % |
|---|---|---|---|---|---|
| July 2010/June 2011 | 5,015 | 4,820 | 96.1 | 195 | 3.9 |
| July 2011/June 2012 | 6,015 | 5,811 | 96.6 | 204 | 3.5 |
| July 2012/June 2013 | 5,880 | 5,623 | 95.6 | 257 | 4.4 |
| July 2013/June 2014 | 6,719 | 6,470 | 96.3 | 249 | 3.7 |
| July 2014/June 2015 | 7,216 | 6,958 | 96.4 | 258 | 3.6 |
| **Total** | **30,845** | **29,682** | **96.2** | **1,163** | **3.8** |

### 5.2.1 School Community perspective on Teenage pregnancy:

From the teachers' perspectives with regards to the acceptance of contraceptive use by teenagers, almost two thirds 62% (8 of 13) of the participants discouraged the fact that teenagers should use contraceptives. However, just less than one third (2 of 13) of the participants encouraged it.

When the issue of parental consent for teenage contraception use was explored, the majority 85% (11 of 13) of the participants indicated it was important to involve parents, as teenagers are still minors, however, two15% (2 of 13) cautioned that involving parents could discourage teenagers from using contraceptives. These were some of the reasons offered:

*"No, I will never encourage contraceptive use, because if you encourage it you are encouraging immorality, which is against the word of God and His commandments. Never, my child should abstain, which is what God says" (a school head teacher).*

*No, because it is not a solution to pregnancy prevention but abstinence is the real thing" (a teacher).*

*“No, it is not necessary to…..because if you ask their parents to come, then they will not use it” (a teacher).*

In terms of the safety of the school environment, the majority 85% (11 of 13) of the participants indicated that the schools environment is now safe and conducive for adolescents since teachers are now empowered to offer SRH and counseling to students, but only two did not believe this to be so. When probed further from those who still believe that the school environment is not safe, one of the participants revealed that some teachers engage in sex with school girls resulting in some becoming pregnant.

Her response was; *“I can say no because some of the male teachers get attracted to our girls and they are using them, they just sleep with them, they are failing as teachers, some of the girls are impregnated by teachers and others are forced to terminate the pregnancy, you see they are not fully safe even in the school”(a female teacher reveals).*

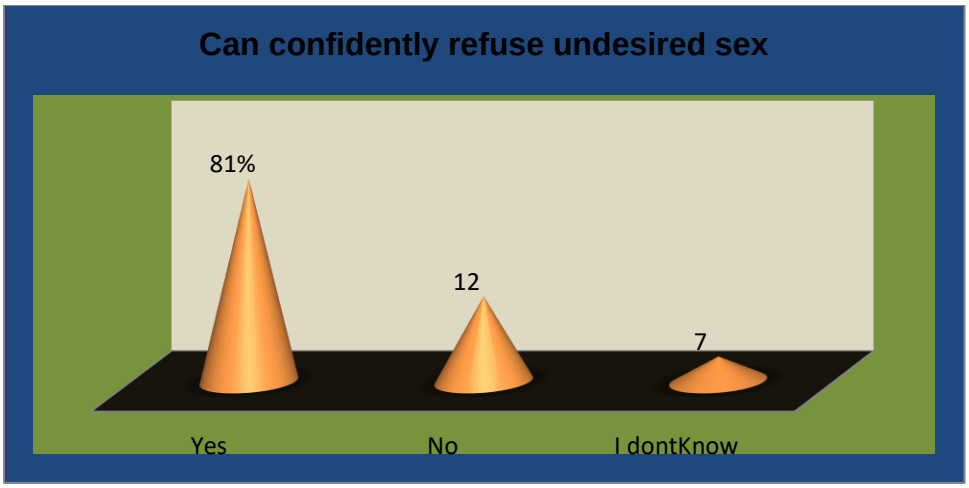
On the significance and existence of parent-child communication, all the participants described parent-child communication as a way that parents can communicate, interact or build rapport with their children, or openness between parents and their children. The small proportion of the participants 31% (4 of 13) indicated the existence of parent-child communication in their homes. Howeverfrom the students’ perspective, more than half 61% (308 of 505) of adolescent samples declined the existence of parents-child communication in their homes.

With respect to parents’ involvement in teenage sexuality education and participation in their child’s education, all the respondents to this question (n = 505) indicated that parents can be involved in teenage sexuality education by educating and giving them adequate information. This could be achievable by attending parents-teachers meetings at schools where they can receive advice on how to get involved in teaching their children sex education. Similarly, parents can also receive sex education in churches or during community meetings.

### 5.3 Life skills

Behavior is the evidence of the predictor of the presence of a Life skill. The study examined thepresence of Life skills amongthe young people. The students were asked whether they would be able to confidently refuse to have undesired sex with their current or future partners.

*Figure 3*



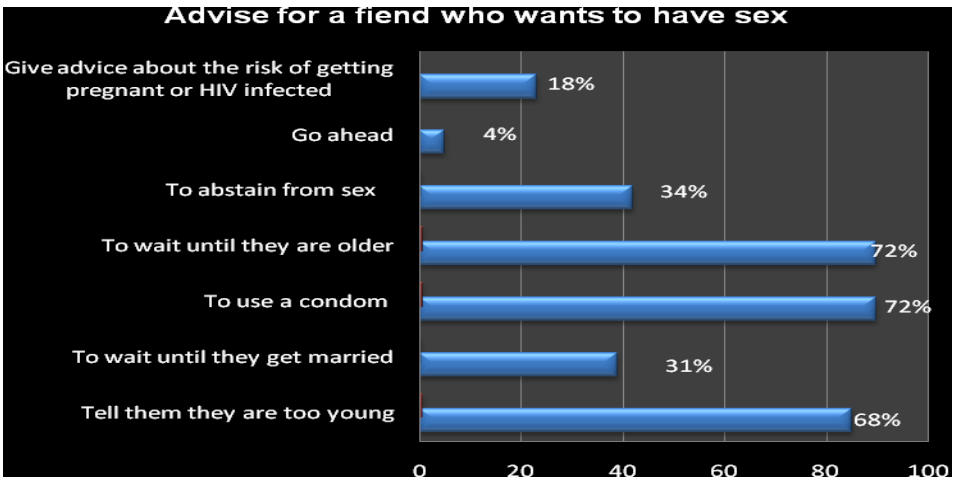

### *5.3.1 Proportion with ability to refuse undesired sex.*

65% (n=328) of the students said they are able to confidently refuse undesired sex while 27% (n=136) stated that they could not. Another 8% (n=40) were not sure. When the data is anlysed by sex it revelaed that about 35% and 27% of the girls and boys respectively cannot confidently refuse to have undesired sex .

### *5.3.2 Advice to a friend on sex*

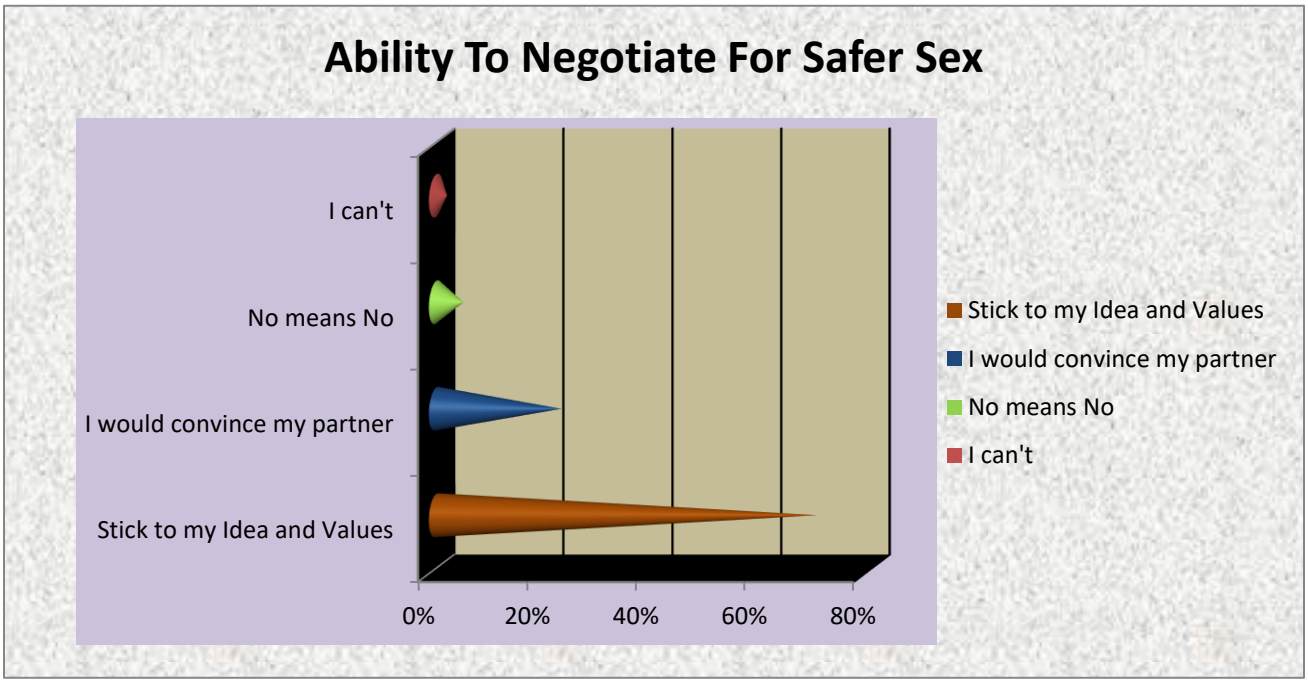
The next question of investigation was what safer sex options they are more likely to engage or adopt.

Most 364 (72%) of the young people would advise a friend who wants to have sex to use a condom while a considerable number could advise them to wait until they are old enough. 379 (75%) of the girls and 354 (70%) of the boys favored this option. There was a greater increase in the number of students who encourage their friends to abstain during post test evaluation of 68% (n=343) compared to those who voulcherd for abstainance during a pre-test. During a pre-test, there was small proportion (23% girls and 16% boys) that suggested that they would discourage their peers form having sex because of the fear of getting pregnant or a STI. On the whole they felt that they would advance the reason of age to discourage their peer from having sex. Only about a third of the students felt abstinence form sex was a viable option.



### 5.3.3 Negotiating for safer sex

The ability to negotiate for safer sex was one which seemed to challenge many of the respondents. From the options provided (n=354)70% of the students said they could stick to their ideas and values while another (n=136) 27% said they would be able to convince him or her while only 3% could fail. These two options involve the ability tonegotiate,communicate and or assert one self.




## 6.0 Influences that tend to exert pressure to the young people

#### *6.0.1 Proportion with friends that have had sex*

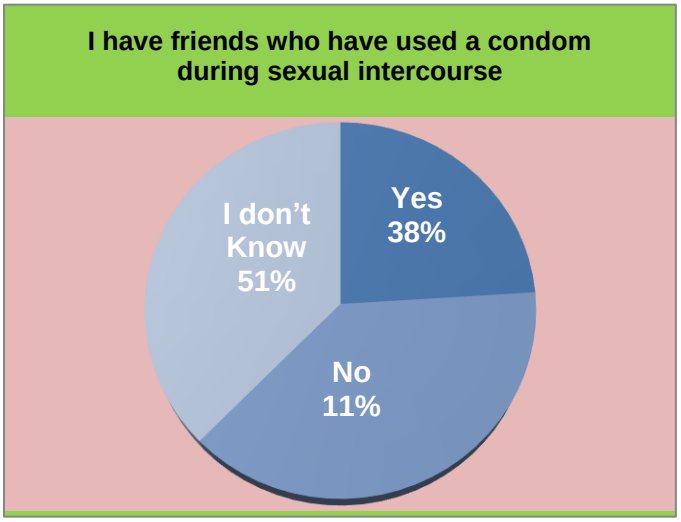
There are many influences that are likely to affect the young people and consequently how they behave. The findings revealed that 40% (n=201) of the students indicated that their friends had had sex by the time of the study. When the data was desegregated by sex and age it revealed that the older students (17 and above) had more friends had had been involved in sex at 42% (n=84) compared to the younger (13-16) of whom 35% know of friends that had been involved in sex. The trends show that the older the children grow the more likely they know about the sexual exploits of their peers.

#### *6.0.2 Proportion who know friends that use condoms for sex*

The study also found out that up to only 38% of the students scored that they have friends who use condoms, while most of them (74%) indicated that they have friends that are abstaining from sex.

The behaviors of young people can also be shaped by the community expectations and norms. Close to 80% (n=404) of the young people reported that the school and community values are against cross generational sexual relationships (relationships either older men or women).

Close to 40% of the target population have talked to an adult about sex, pregnancy and HIV; It was however not clear who the young people talked to; to source for such information. It was not clear what specific information relating to this topic they sought for. The information about sex is largely sought from their peers with the girls then ranking the health workers as second while the boys prefer to get information from their teachers as the second option. Parents for both sexes come as the number four source of information n sex.




The health care providers are reported to be approachable especially for 56% of the girls and 47% of the boys. Interestingly forthe young people to access these services almost all of them (90%) said they required the permission of either their teachers or Parents.

## Sexualknowledge and practices

The section examined the sexual practices of the young people are involved in sexual relationships and their sexual practices. Close to 80% of the students indicated that they are involved in a relationship with members of the opposite sex and 43% of them scored that they had had sex. The survey however, did not ascertain whether the sexual relationship were with the current friends.

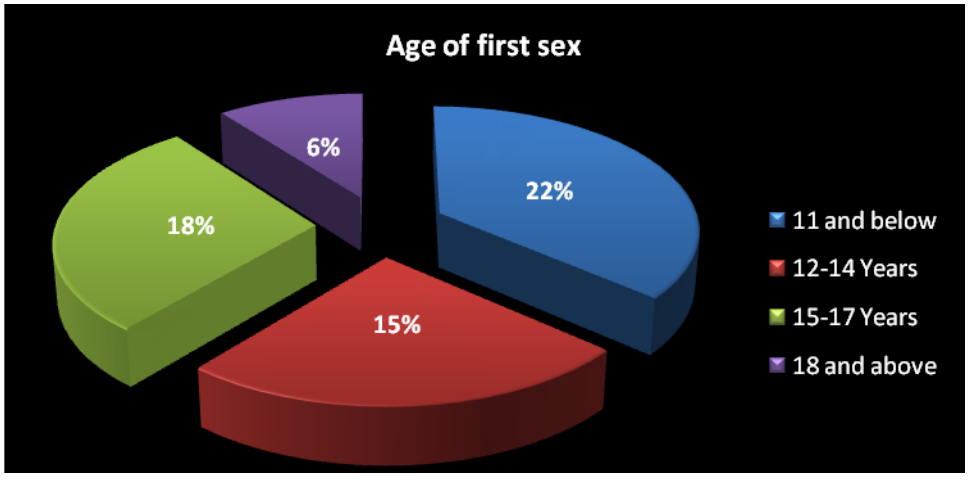



*Figure 4: Proportion of those that recognize risk related to unprotected sex.*

## SRH Attitudes and risk perception.

The students were asked if they felt they would be at risk of getting an STI if they did not use a condom for sex. The majority 62% stated that they would be at risk while a significant proportion (about 4 out of 10) is not aware of the risk. Evidently the perception of risk of the3 other is very poor. There is however a sharp contrast with the responses to a similar question in relation to pregnancy. Close to 7 in 10 students recognized that unprotected sex could lead to a pregnancy

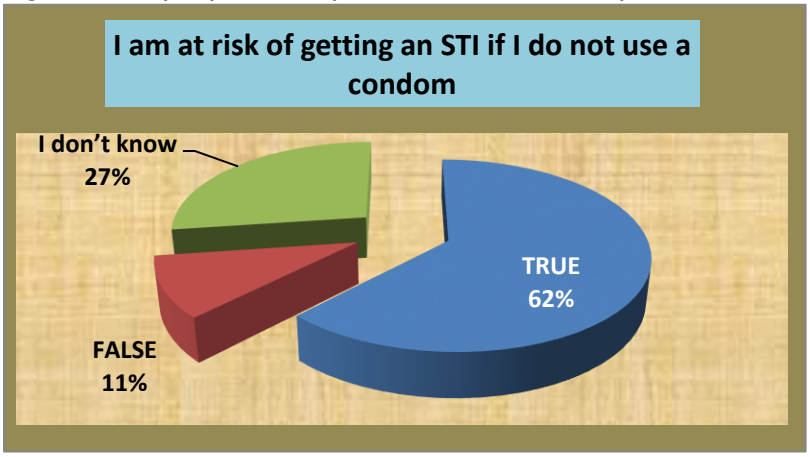
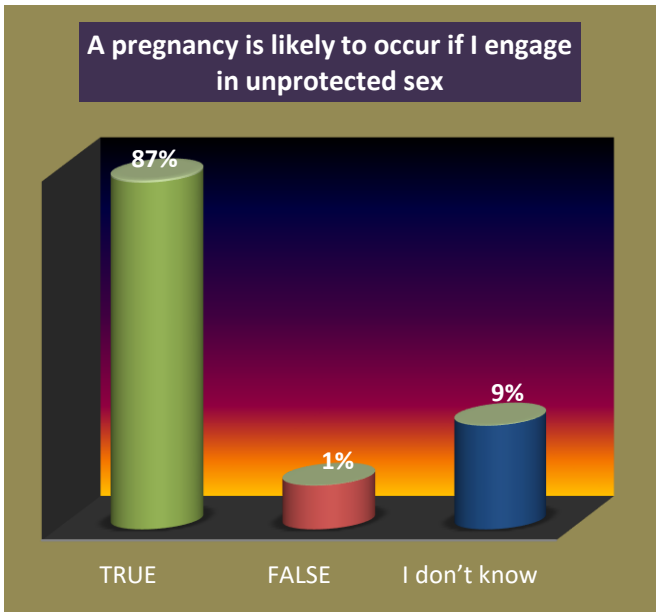



*Figure 5: Proportion that know unprotected sex could lead to pregnancy*

This confirms what other studies have discovered that young people are more worried about pregnancy than acquiring a STI or HIV. It is this reality that inhibits their ability to recognize risk in relation to a STI or HIV. There is 11% (n=56) of the students who are not aware that unprotected sex could result into a pregnancy. When this data is desegregated by it revealed that up to sex up to 11% of the girls do not know that having unprotected sex could lead to pregnancy.

Three in four girls think that young people should always use condoms for sex this could be in part because again only one in four girls believe that it is not acceptable to get condoms in their community and school. Almost 70% of the boys think that condoms should be used all the time for sex.While two third feel it is acceptable to access condoms in the community and school.



## Influences on the young people

There are many influences in thelives of the students. These include teachers, and peers in the school setting and the Parents inthe community. Only 25% of the students said they were comfortable discussing sexual issues withtheir teachers.

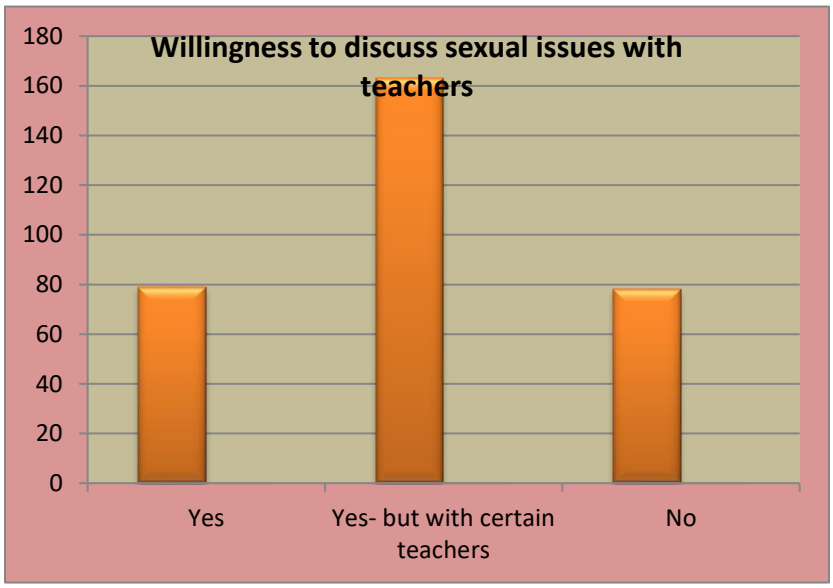
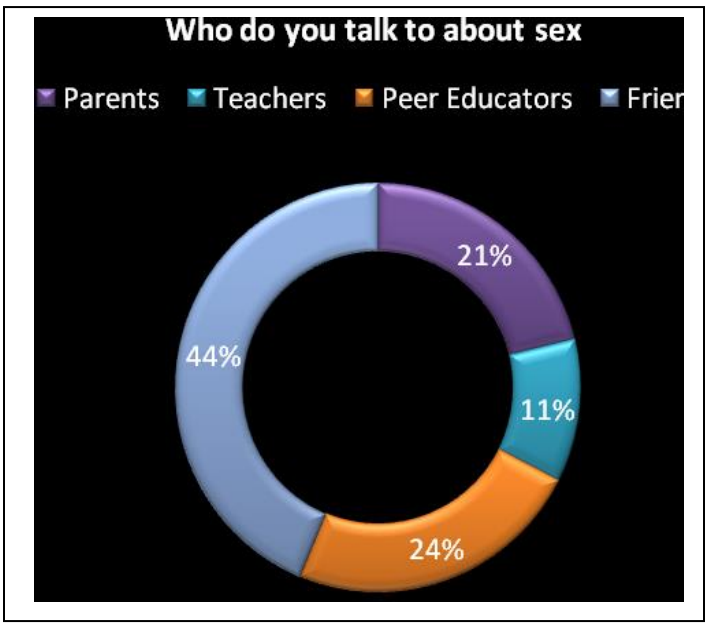



*Figure 6: Student Vs Teacher discussion on sex.*

Evidently the teachers may not be a first pointof call for the students.

44% of the students have friends that have had sex before and half of them have been influenced by their friends to have sex. Many of the students (68%) have talked to an adult about sex, HIV and pregnancy.

However students mostly talk to their friends on issues of sex,peer educators, parents and lastly teachers.




Teachers are not as trusted because the students fear that they are likely betray the confidence, fear and the fact that because they are nottheir peers they would not know how to relate to them.

**Conclusion;**

The study provided evidence of the applicability of the stake holder/ evidence based model to community participation in teenage pregnancy prevention. The model focuses on the school and community as a whole and partnering with the stakeholders is an important aspect of working in the community. The main function of the teachers is to assist the community to reach, maintain and promote health issues with the aim of acting as a health advocate or facilitator so that adolescents can have the necessary power that will help to control its reaction to the high prevalence of unplanned teenage pregnancy within the community. Peers time and again have been found to be a reliable source of information young people and programs target peers as mentors have proved to be effective in changing ASRH behaviors and attitudes among young people.

**Recommendations.**

Based on the findings of the study, the following are recommended:

1. Cultural myths/beliefs that encourage teenage pregnancy should be corrected by the registered nurses. This could be done through the provision of health education to parents and the community at large, where the disadvantages of teenage pregnancy are properly emphasised.
2. School administrations and teachers should organise regular sexuality education campaigns and life skills workshops for peers in, schools on regular basis to enhance young people's ASRH.
3. Early sex education at home by parents and other adults should be encouraged.
4. Parents and guidance should be encouraged by the teachers and other community stakeholders to participate adequately in their children's education as well as in all other aspects of life. Parents should attend parent-teachers meeting and do regular follow-up on their children performances and behaviors in the school.
5. Health professionals need to work together with the government and other non-governmental organizations that are providing youth-friendly services and campaigns to inform teenagers and the community at large about teenage sexual and reproductive health.
6. The community at large should be made to understand the importance of open communication between parents and their children. This could be done through the use of campaigns, workshops and rallies in the health centers/ clinics, community centers, social, cultural and religious groups.
7. Contraceptive use amongst sexually active teenagers should be encouraged by all stakeholders in the community, especially the practice of dual protection, which involves safe and protected sex. The Municipal Departments of Health together with Education should provide extended clinical services in schools in order to provide accessible confidential services to teenagers.

8. Safe and conducive school environments that are able to monitor learners' movements, prevent sexual harassment specifically by the teachers and provision of adequate security should be guaranteed by the school authority. Appropriate punishment of teachers found guilty of abusing their students' sexual reproductive health rights must be ensured.
9. And conclusively, community awareness campaigns about the possible consequences of teenage pregnancy and childbirths should be undertaken.

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