Knowledge, Attitudes And Practices Regarding Family Planning Characteristics Among Adolescents In-School And Out Of School Adolescents In Kavango Region, Namibia.

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Abstract: *The objective of this study was to determine the knowledge, attitudes and practices regarding family planning methods among the in-school and out of school adolescents in Kavango region, Namibia and identify the association between the sexual and reproductive health characteristics of the adolescents.*
A cross-sectional analytical study was conducted using mixed methods - quantitative and qualitative approaches among 350 school learners (grade 6 to grade 12) and 150 school drop-out adolescents (aged 12 to 19 years). The stratified random sampling techniques were used in the selections of the circuit and the schools. Structured questionnaires were used and in depth interviews were conducted among the key informants (teachers).
The following variables were included in the family planning characteristics contraceptive methods known, contraceptive methods used, 1st pregnancy ,current pregnancy, talk attended on contraceptives, sexually transmitted diseases and pregnancy; contraceptives requested and number of times services sought;STD and 1st pregnancy, low condom used and no contraceptives used.
Descriptive statistics were used to summarise the different variables. Cross-tabulations of, family planning variables were used to describe the relative frequencies.
The associations between different categorical variables were assessed using Chi-square test whilst the identification of different determining factors were analyzed with the epidemiological methods using odds ratios and/or estimated relative risks.
The study found that family planning characteristics such as: talk attended on contraceptives,; contraceptives requested and number of times services sought; contraceptive used and currently pregnant;STD and 1st pregnancy, low condom used and no contraceptives used, education level ,early sexual debut, first sexual intercourse, number of sexual partners, relationship with sexual partners older than 5 years and dropping out of school were associated with adolescent pregnancy in Okavango region.
Keywords: Adolescents, Contraceptives, Family planning methods, Reproductive health, Sexual health

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I. Introduction

The article covers the results related to the study to determine the knowledge, attitudes and practices regarding family planning methods among the in-school and out of school adolescents in Kavango region, Namibia and to identify the association between the sexual and reproductive health characteristics of the adolescents.

Teenage pregnancies give an impression of being unwanted because they are never planned. According to (USAID, 2011) 91% of teenage pregnancies in the Okavango region in Namibia were unwanted. The unplanned and unwanted pregnancies among teenage girls are often terminated by unsafe abortions which may have a long term negative effect on their social and emotional being. The Demographic Health Survey as reported in Ministry of Health & Social Service, (MOHSS) 2013 and USAID 2011study revealed that the teenage pregnancy rate in the Kavango Region was double the national average, standing at 34% among the 15-19 year old. The national average teenage pregnancy rate was 15% and 15.4% respectively; and three times the rates in some of the neighboring regions, such as Ohangwena, Omusati, and Oshana.

In Namibia, 2015 the prevalence of adolescent pregnancy was 31.3%; and as stated by Lillian and Mumbango, 2015 adolescent pregnancy was influenced by generation, region, highest educational level, socio-economic status and cultural factors. Therefore, intervention programs and policy initiatives should focus on youth, regions, everyone regardless of the socio-economic or culture.

Although different regions of Namibia are affected, Okavango region in Northern Namibia is mostly affected by the problem of teenage pregnancy. According to a USAID report (USAID, 2011), the region has the highest rate of 34% teenage pregnancy among 15 to 19 year olds.

The statistics provided by United Nations Population Fund (UNFPA, 2013), stated that there were 245 431 adolescent girls population in Namibia aged between 15 and 19.

46 000 adolescent fell pregnant, 66% of the population between 15 and 19, 39% below the age of 15.

As previously pointed out, the pregnancy rates are high in some regions, with 20% of teenagers in some rural areas becoming mothers earlier than their counterparts in urban areas. One of the reasons being is that rural teenage girls only have primary-level education, while girls in urban areas are better educated. Apart from the academic factor, the report also said some girls do not know how to avoid falling pregnant, while others feel shy or are ashamed to access contraceptives (Kangootui, 2016; UNFPA, 2013).

The USAID report (2011) on teenage pregnancy in Okavango region indicates that lack of access to family planning as a result of the traditional orientation of family planning in favor of older and married women by health care providers is partly responsible for teenage pregnancy in the region. Furthermore, the report indicated that while 98% of young people in Okavango were informed about contraceptives, but only 8.7% of them use it.Condom use in the Okavango Region was very low at 36%.

A report from a local study indicates that a number of risk factors have been linked to teenage pregnancy (Simon, 2013). These include early sexual activities and poor use of contraceptive, poverty or low socio-economic status, poor school performance and low self-esteem or depression.
Adolescent pregnancy was considered a private matter that only involved the pregnant adolescent and the immediate family members. This issue has now however become a public concern. An increasing awareness of social and economic consequences of adolescent pregnancy has led to a consensus among researchers and policy makers and the general public at large that adolescent pregnancy and childbearing is a serious social problem. It is linked to concerns such as the spread of HIV/ AIDS, non-marital births, sexual abuse and neglect, abortions, infant and maternal mortality, high rate of unemployment, school failure and drop-outs, and loss of self-esteem and limited future career opportunities (Lillian and Mumbango, 2015).

II. Material And Methods

A cross-sectional analytical study was conducted using mixed methods - quantitative and qualitative approaches among 350 school learners (grade 6 to grade 12) and 150 school drop-out adolescents (aged 12 to 19 years). The stratified random sampling techniques were used in the selections of the circuit and the schools. Structured questionnaires were used, and in depth interviews were conducted among the key informants (teachers). The following variables were included the family planningcharacteristics contraceptive methods known, contraceptive methods used, 1st pregnancy ,current pregnancy, ANC , STD ,residential address and gender of participants.
Study Design: Cross-sectional analytical study was conducted using mixed methods - quantitative and qualitative approaches.
Study Location: Public primary and secondary schools and as well   different constituencies in the communities in Okavango region.
Study Duration: March 2016-August 2016
Sample size:540 adolescents

Sample size calculation:A sample size of 500 adolescents was determined using Epi-info version 7 considering at least 95% significance level for the quantitative approaches. For the qualitative approaches 15 school learners and 25 teachers went through an in-depth interview. In total a sample of 540 was utilized.
Subjects & selection method: The study population groups were three-fold, the school learners in primary or secondary school, the teachers at different schools and the adolescents in the community who had dropped out of school.

The first target population was the school learners falling within the age group of between 12- 19 years, in public primary and as well secondary schools in Okavango region. The second target population were teachers at different schools teaching Life Science, Life Skills, Biology or Natural Science .The third target populations were the adolescent's in the communities who had dropped out and or never went to school and falls within the age group of between 12- 19 years.
The stratified random sampling techniques were used in the selections of the circuit and the schools. Structured questionnaires were used in face-to-face interviews, and in-depth interviews were conducted among key informants (teachers).

Inclusion criteria:
- Adolescents, 12-19 years.
- School goers.
- Willingness to participate.
- Good understanding and comfortable with English language.
- Agree to answer general health questions related to risky behaviours.

Exclusion criteria
- Adolescents below 12 years and above 19 years
- Out of school
- Not willing to participate
- Not understanding and not comfortable with English language
- Does not agree to answer general health questions related to risky behaviours.

Procedure methodology.
Datacollection: preparing the field,
For both the schools and the community: Prior telephonic arrangements were done with the school principals and councilors regarding the purposes of the visit, date and time for the visits to Kavango region and to the specific schools.

Data collection procedure at schools
      The researcher reported at the principal office whereby the researcher submitted all written proof of letters for permission as obtained from the different institutions.
      The principal accompanied the researcher to the Laboratory classroom or Life Skills class where the data collection took place. At some schools, the teacher responsible for Life Science, Life Skills, Natural Science or Biology accompanied the researcher. At some instances the learners waited at the mentioned classrooms and at other schools learners were called for the data collection once the researcher turned up.
      The researcher was provided in advance with the class list of the specific grades, and carried out simple random selection. At the Primary schools: all learners from the different grades 6-7 came to the one central classroom, which was the Life Skills class's room. At the Secondary schools: all learners from the different grades 8-12 came to the one central classroom, which was the Life Skills, Biology or the laboratory classroom.
      After explaining the aims of the study and obtaining permission from the learners, the researcher distributed the questionnaires to each learner. The questionnaires were in English and consisted out of open ended close questions. The researcher utilized questionnaires with the learners to understand their take on the curriculum provided at schools. Questionnaires on the learners were used to collect data and an individual in-depth face-to-face interview was carried out with the teachers offering at school the abovementioned subjects. The teacher's in-depth interview pointed out their challenges, experiences and shortcomings with the implementation of the curriculum. The data collected by the main researcher focused on reproductive issues, whether it is included and discussed comprehensively or partly in the abovementioned subjects.
      The questionnaire's consisted out of five subsections which were as follows: demographic data, sexual and reproductive health characteristics, potential risk factors, family planning and social background.

Data collection procedure in the community
The constituencies were visited on different days. The researcher reported at the constituencies' office and the representative of the councilor was waiting as prior arranged.

Statistical analysis
      Data were entered and analyzed using SPSS software version 23. Descriptive statistics was used to summarize the different variables. Cross-tabulations of family planning variables were used to describe the relative frequencies. The associations between different categorical variables were assessed using Chi-square test whilst the identification of different determining factors was analyzed with the epidemiological methods using odds ratios and/or estimated relative risks. The means, standard deviation and 95 % confidence interval were computed. The differences between different variables or factors were considered to be statistically significant for p-values less than 0.05.

III. Result
Table no 1: Descriptive Statistics

	N Statistic	Mean Statistic	Std. Error	Std. Deviation Statistic	Skewness Statistic	Std. Error	Kurtosis Statistic	Std. Error
Age	500	16.01	.107	2.384	-.476	.109	-.892	.218
Age of first sexual intercourse	238	15.40	.135	2.086	-.393	.158	-.377	.314
Number of sexual partners in the past 12 months	224	1.83	.073	1.099	1.567	.163	2.677	.324
Age	498	42.14	.364	8.123	-.153	.109	2.053	.218
Age at Abortion	13	16.77	.343	1.235	.200	.616	-.808	1.191
Amount of pocket money received from parents	355	197.83	10.721	202.007	1.796	.129	4.034	.258

Table no 1: provides the following: The mean age of respondents was 16 years, with a standard error of 0.107 and a standard deviation of 2.384.

Age of first sexual intercourse was 15 years, with a standard error of 0.135 and a standard deviation of 2.086.

Number of sexual partners in the past 12 months in total 224 out of 500 where having more than 1 sexual partner with a mean of 1.83, with a standard error of 0.073 with a standard deviation of 1.099.

Table no 2: Family planning ADFHS characteristics-Association between talk attended on contraceptives,STD and visited health facility

		Talk contraceptives			P- value
		Yes	No	Total	
Visited Health Facility	Yes	110	81	191	0.001
	No	95	131	226	
	Not applicable	50	33	83	
Total		255	245	500	
STD					
Visited Health Facility	Yes	138	53	191	0.002
	No	128	98	226	
	Not applicable	59	24	83	
Total		325	175	500	

* P-value statistically significant at the level of significant 0.05

Table no 2: pointed out the association statistically significant was found between talk attended on contraceptives and visited health facility (p –value of 0.001<0.05). Similarly, the talk attended on sexually transmitted diseases and visited health facility were statistically highly significant p –value of 0.002<0.05).

Table no 3:.Family planning characteristics – Association between contraceptive used and currently pregnant

		Contraceptive used			
		Yes	No	Total	p-value
Currently Pregnant	Yes	29	37	66	0.018
	No	128	306	434	
Total		157	343	500	
Contraceptives requested					
Services	Number of times	107	92	199	0.017
	Did not seek care in 12 months	48	32	80	
	Not applicable	96	125	221	
Total		251	249	500	

* P-value statistically significant at the level of significant 0.05

Table no 3: illustrate the association between contraceptives used and currently pregnant is statistically significant (p –value =0.018. <0.05).The association between contraceptives requested and number of times services sought is statistically significant with a p –value of 0.017.

Table no 4:Risk Estimate

STD		Value	95% Confidence Interval	
			Lower	Upper
Total	Odds Ratio for Use contraceptives (Yes / No)	1.057	.626	1.784
	For cohort Pregnant = Yes	1.049	.666	1.654
	For cohort Pregnant = No	.993	.927	1.063
	N of Valid Cases	500		
STD				
Total	Odds Ratio for Methods (Yes / No)	.813	.480	1.380
	For cohort Pregnant = Yes	.836	.530	1.319
	For cohort Pregnant = No	1.028	.956	1.106
	N of Valid Cases	499		
STD				
Total	Odds Ratio for Contraceptives before (Yes / No)	.840	.483	1.462
	For cohort Pregnant = Yes	.859	.529	1.394
	For cohort Pregnant = No	1.023	.954	1.097
	N of Valid Cases	500		

Tableno 4: The adolescents who used contraceptives with 95 % confidence interval odd ratios varying between 0.666 to 1.654; the researcher found that those who used contraceptives were 1.049times at risk of getting pregnant and those who do not used contraceptives were 0.993 times at risk of getting pregnant, with 95 % confidence interval odd ratios varying between 0.927 to 1.063.
The above results show that the adolescent who used contraceptives have a minimum risk of getting pregnant 0.993 times and a maximum risk of getting pregnant 1.049 times.
Table no 4:illustrated ,the adolescents who became pregnant with 95 % confidence interval odd ratios varying between 0.530 to 1.319;the researcher found that those who became pregnant were having 0.836 chances of using contraceptives methods and those who did not became pregnant were having 1.028 chances of not using contraceptives methods, with 95 % confidence interval odd ratios varying between 0.956 to 1.106.The results show that the adolescent who became pregnant have minimum chances of using contraceptives methods of 0.836 times and a maximum chances of using contraceptives 1.028 times.
In **Table no 4: it** pointed out that ,the adolescents who became pregnant with 95 % confidence interval odd ratios varying between 0.529 to 1.394;the researcher found that those who became pregnant were having 0.859 chances of using contraceptives before and those who did not become pregnant were having 1.023 chances of not using contraceptives before, with 95 % confidence interval odd ratios varying between 0.954 to 1.097.The results show that the adolescent who became pregnant have minimum chances of using contraceptives before of 0.859 times and a maximum chances of using contraceptives before of 1.023.

Table no 5: Family planning characteristics – Association between contraceptives used, STD and 1st pregnancy

STD			1st pregnancy			Total	P-value
			Yes	No	Not applicable		
Once	Use contraceptives	Yes	1	6	153	160	
		No	4	3	112	119	
	Total		5	9	265	279	
More than once	Use contraceptives	Yes	1	4	36	41	0.009
		No	5	2	20	27	
	Total		6	6	56	68	
Never	Use contraceptives	Yes	3	3	75	81	
		No	7	5	60	72	
	Total		10	8	135	153	
Total	Use contraceptives	Yes	5	13	264	282	
		No	16	10	192	218	
	Total		21	23	456	500	

* P-value statistically significant at the level of significant 0.05
Table no 5: stated the association between contraceptives used, STD and 1st pregnancy is statistically significant (p –value = 0.009<0.05).

Table no 6: Family planning characteristics characteristics- Association between contraceptives requested and doctor/nurse

		Contraceptives requested			p-value
		Yes	No	Total	
Dr/Nurse	Contraception	103	73	176	0.010
	STD	45	39	84	
	Pregnancy test	60	69	129	
	Other	43	67	110	
Total		251	248	499	
Services	Number of times	137	62	199	0.010
	Did not seek care in 12 months	1240	40	80	
	Not applicable	133	88	221	
Total		310	190	500	

* P-value statistically significant at the level of significant 0.05
Table no 6: showed the association between contraceptives requested and doctor/nurse and as well the association between contraceptives used and number of times services sought both is statistically significant (p – value of 0.010 respectively).

Table no 7: Family planning characteristics – Association between talk on pregnancy and last visit at the health facility

		Pregnancy			p-value
		Yes	No	Total	
Last visit	Government	211	146	357	0.013
	Private	32	42	74	
	Other	32	37	69	
Total		275	225	500	

* P-value statistically significant at the level of significant 0.05
Table no7: stated the association between talk on pregnancy and last visit at the health facility is statistically significant (p –value of 0.013).

Table no 8: Family planning characteristics –Association between visit of health facility, confidentiality and talk contraceptive

Confidentiality			Talk contraceptives			P-value
			Yes	No	Total	
Yes	Visit HF	Yes	78	46	124	
		No	48	42	90	
		Not applicable	38	17	55	
	Total		164	105	269	
No	Visit HF	Yes	32	35	67	0.001
		No	47	88	135	
		Not applicable	12	15	27	
	Total		91	138	229	
Total	Visit HF	Yes	110	81	191	
		No	95	130	225	
		Not applicable	50	32	82	
	Total		255	243	498	

* P-value statistically significant at the level of significant 0.05

Table no 9: Family planning characteristics- Association between gender of participants and contraceptives used

			Gender of participants			
			Male	Female	Total	p-value
Contraceptives Used	Yes	Count	55	99	154	
		% within Contraceptives used	35.7%	64.3%	100.0%	
		% within Gender of participants	28.8%	38.7%	34.5%	
		% of Total	12.3%	22.1%	34.5%	
	No	Count	136	157	293	0.030
		% within Contraceptives used	46.4%	53.6%	100.0%	
		% within Gender of participants	71.2%	61.3%	65.5%	
		% of Total	30.4%	35.1%	65.5%	
Total		Count	191	256	447	
		% within Contraceptives used	42.7%	57.3%	100.0%	
		% within Gender of participants	100.0%	100.0%	100.0%	
		% of Total	42.7%	57.3%	100.0%	

* P-value statistically significant at the level of significant 0.05

Table no 9: illustrates the association between gender of participants and contraceptives used is statistically significant with a p –value of 0.030.

Table no 10: Family planning characteristics- Association between condom used, drug and sex partner

Drug			Sexual Partner							Total	P-value
			1	2	3	4	5	6	7		
Yes	Condom Used	Yes	2	1	0	2				5	
		No	1	2	2	0				5	
	Total		3	3	2	2				10	0.001
No	Condom Used	Yes	84	26	18	10	3	1	1	143	
		No	22	28	1	6	0	0	0	57	
	Total		106	54	19	16	3	1	1	200	
Total	Condom Used	Yes	86	27	18	12	3	1	1	148	
		No	23	30	3	6	0	0	0	62	
	Total		109	57	21	18	3	1	1	210	

			1	2	3	4	5	6	7	Total	P-value
Tertiary	Condom Used	Yes	24	4	5	5	2			40	
		No	9	8	0	5	0			22	
	Total		33	12	5	10	2			62	
High School	Condom Used	Yes	34	11	4	4	1		1	55	0.001
		No	9	16	1	0	0		0	26	
	Total		43	27	5	4	1		1	81	
Primary School	Condom Used	Yes	27	12	9	3		1		52	
		No	5	6	2	1		0		14	
	Total		32	18	11	4		1		66	
Don't know	Condom Used	Yes	1							1	
	Total		1							1	
Total	Condom Used	Yes	86	27	18	12	3	1	1	148	
		No	23	30	3	6	0	0	0	62	
	Total		109	57	21	18	3	1	1	210	

* P-value statistically significant at the level of significant 0.05

**Table no 11: Sexual and reproductive health characteristics-
Association between condom used, orphan and sex partner**

Orphan			Sexual Partner							Total	P-value
			1	2	3	4	5	6	7		
Yes	Condom Used	Yes	18	7	7	6				38	
		No	7	13	3	1				24	
	Total		25	20	10	7				62	
No	Condom Used	Yes	68	20	11	6	3	1	1	110	0.001
		No	16	17	0	5	0	0	0	38	
	Total		84	37	11	11	3	1	1	148	
Total	Condom Used	Yes	86	27	18	12	3	1	1	148	
		No	23	30	3	6	0	0	0	62	
	Total		109	57	21	18	3	1	1	210	
Yes	Condom Used	Yes	15	4		1			1	21	
		No	5	4		0			0	9	
	Total		20	8		1			1	30	
No	Condom Used	Yes	71	23	18	11	3	1		127	0.001
		No	18	26	3	6	0	0		53	
	Total		89	49	21	17	3	1		180	
Total	Condom U	Yes	86	27	18	12	3	1	1	148	
		No	23	30	3	6	0	0	0	62	
	Total		109	57	21	18	3	1	1	210	

* P-value statistically significant at the level of significant 0.05

Table no 11: pointed out the association statistically significant was found between condom used, drug and sex partner and as well between condoms used, education and sex partner. However the same was found between condom used, orphan and sex partner and condom used, partner older and sex partner were statistically highly significant p –value of 0.002<0.05).

Table no 12:Risk Estimate

Orphan		Value	95% Confidence Interval	
			Lower	Upper
Total	Odds Ratio for Abortion (Yes / No)	.649	.176	2.390
	For cohort Contraceptives. = Yes	.730	.268	1.986
	For cohort Contraceptives. = No	1.125	.830	1.524
	N of Valid Cases	500		

Total　　Odds Ratio for Study ---……... status (school / Dropout)	1.464	.760	2.820
For cohort Pregnant = Yes	1.378	.786	2.415
For cohort Pregnant = No	.942	.856	1.036
N of Valid Cases	384		

Table no 12: provide the adolescents study status who became pregnant with 95 % CI OR varying between 0.786 to 2.415; the researcher found that those who became pregnant were 1.378 times at risk of dropping out of school and those who didn't became pregnant were 0.942 times at risk of dropping out, with 95 % CI OR varying between 0.856 to 1.036.

The above results show that the adolescent who became pregnant have a minimum risk of dropping out of school 0.942 times and a maximum risk of dropping out of school 1.378 times.

Table no 13: Risk Estimate

Physical Abused		Value	95% Confidence Interval	
			Lower	Upper
Total	Odds Ratio for Abortion (Yes / No)	.649	.176	2.390
	For cohort Contraceptives. = Yes	.730	.268	1.986
	For cohort Contraceptives. = No	1.125	.830	1.524
	N of Valid Cases	500		

Table no 13: illustrated the orphans with 95 % confidence interval odd ratios varying between 0.268 to 1.986 for those using contraceptives and the researcher found that the orphan adolescents are having 0.730 times chance of performing abortion. And for those not using contraceptives having 1.125 chances of performing an abortion with 95 % confidence interval odd ratios varying between 0.830 to 1.524.

The physical abused with 95 % confidence interval odd ratios for those using contraceptives varying between 0.268 to 1.986 and having 0.730 times chances of performing abortion.

And for those who were not using contraceptives were having 1.125 chances of performing a abortion with 95 % confidence interval odd ratios varying between 0.830 to 1.524 .The researcher found that there is a statistically association between the orphans and the physical abused.

IV. Discussion

　　Adolescent pregnancy prevention research and programs predominantly focus on factors controlled by the adolescent girl. However, the most important factors linked to early pregnancy in this study were, contraceptive methods known, contraceptive methods used, 1st pregnancy ,current pregnancy, ANC , STD ,residential address and gender of participants, talk attended on contraceptives, sexually transmitted diseases and pregnancy; contraceptives requested and number of times services sought; STD and 1st pregnancy, low condom used and no contraceptives used.

　　The USAID reported that ignorance among the adolescent girls is also to blame for teenage pregnancy. The report indicates that while 98% of young people were informed about contraceptives, but only 8.7% of them use it. This claim is also substantiated by UNICEF's report, which indicates that adolescent girls in Namibia have low level of contraceptive use and, only above 61% of condom use(The United Nations Children's Fund (UNICEF), 2012).

　　Teenage pregnancy appears unwanted because it is unplanned. This is substantiated by the study on teenage pregnancy by the USAID (USAID, 2011)in Namibia the findings of which has proven that 91% of pregnancies among teenagers in Okavango region of Namibia were unwanted. Unplanned teenage pregnancy is often terminated by abortion, a negative experience that may have a lifelong emotional and social impact on her.

　　Teenagers in some rural areas becoming mothers earlier than their counterparts in urban areas. One of the reasons being is that rural teenage girls only have primary-level education, while girls in urban areas are better educated. Apart from the academic factor, the report also said some girls do not know how to avoid falling pregnant, while others feel shy or are ashamed to access contraceptives (Kangootui, 2016; UNFPA, 2013).

　　Adolescent pregnancy was considered a private matter that only involved the pregnant adolescent and the immediate family members. This issue has now however become a public concern. An increasing awareness

of social and economic consequences of adolescent pregnancy has led to a consensus among researchers and policy makers and the general public at large that adolescent pregnancy and childbearing is a serious social problem. It is linked to concerns such as the spread of HIV/ AIDS, non-marital births, sexual abuse and neglect, abortions, infant and maternal mortality, high rate of unemployment, school failure and drop-outs, and loss of self-esteem and limited future career opportunities (Lillian and Mumbango , 2015).

About 16 million girls aged 15 to 19 years and two million girls under the age of 15 give birth every year. Worldwide, one in five girls has given birth by the age of 18. In the poorest regions of the world, this figure rises to over one in three girls, almost all adolescent births about 95% occur in low- and middle-income countries. Within countries, adolescent births are more likely to occur among poor, less educated and rural populations (WHO, 2014).

As indicated in the study by (Omar, Hasim, Muhammad, Jaffar, Hashim and Siraj, 2010), there were significant associations between adolescent pregnancy and low education level, low socioeconomic status, being raised by a single parent, not engaging in extracurricular school activities, engaging in unsupervised activities with peers after school, and substance abuse being anemic, being unsure of the expected delivery date (Omar, Hasim, Muhammad, Jaffar, Hashim and Siraj, 2010).

V. Conclusion

The study found the following aspects/factors: talk attended on contraceptives, sexually transmitted diseases and pregnancy; contraceptives requested and number of times services sought; contraceptive used and currently pregnant; STD and 1stpregnancy, gender of participants, condom used, education level ,orphaned, drug, partner older and sex partner early sexual debut, first sexual intercourse, number of sexual partners, relationship with sexual partners older than 5 years and dropping out of school were associated with adolescent pregnancy in Okavango region.

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