Prevalence and Associated Factors of Teenage Pregnancy among Female Students in Public Secondary Schools in Uturu, Isuikwato Local Government Area, Abia State

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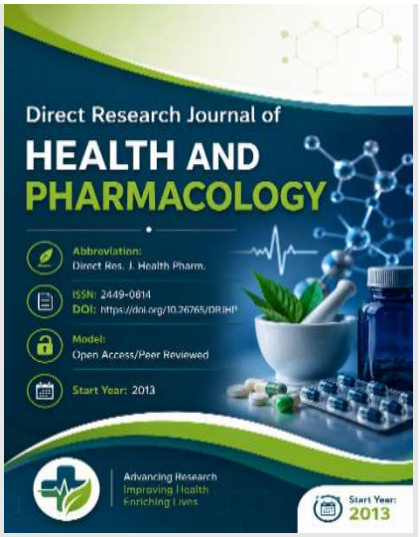
ABSTRACT

Background: *Teenage pregnancy remains a major public health concern because of its adverse health, educational, and social consequences for adolescent girls, their children, families, and communities. Evidence from school-based populations in Uturu, Isuikwato Local Government Area, remains limited.* ***Objective:*** *This study determined the prevalence of teenage pregnancy, identified factors associated with teenage pregnancy, and examined educational implications among female students in Uturu, Isuikwato Local Government Area, Abia State.* ***Methods:*** *A cross-sectional descriptive study was conducted among female students in five public secondary schools. A total of 216 respondents participated in the study (response rate: 100%), and data were collected using a structured questionnaire. Descriptive statistics were used for data analysis.* ***Results:*** *Respondents aged 17 years constituted the largest age group (51, 23.6%). Participants were Christians (185, 85.6%), resided in rural areas (149, 70.0%), and were in senior secondary school (145, 67.1%). Among respondents who had ever had sexual intercourse (148, 68.5%), 82 (55.4%) reported pregnancy. The most frequently reported factors associated with teenage pregnancy were poverty (24, 29.3%), peer pressure (14, 17.1%), and sexual abuse (10, 12.2%). School withdrawal (41, 50.0%) and below-average academic performance following pregnancy (35, 42.7%) were the most commonly reported educational implications.* ***Conclusion:*** *Teenage pregnancy was common among female students and was associated with educational and health-related challenges. Comprehensive sexuality education, strengthened parent-child communication, adolescent-responsive reproductive health services, poverty-sensitive interventions, and measures to prevent sexual abuse may contribute to reducing teenage pregnancy and its associated consequences.*

Keywords: *Adolescent, Adolescent pregnancy; Teenage pregnancy; Reproductive health; Risk factors.*



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INTRODUCTION

Teenage pregnancy remains a persistent public health, educational and social challenge in many low- and middle-income countries (WHO, 2024; Alukagberie et al., 2023). The adolescent birth rate, defined as births per 1,000 girls aged 15-19 years, is widely used as a demographic and development indicator because early childbearing reflects the interaction of poverty, limited schooling, gender inequality, early sexual debut, weak access to contraception and gaps in adolescent-responsive health services (WHO, 2024; Alukagberie et al., 2023). Although adolescent pregnancy has declined in several settings, progress remains uneven, and sub-Saharan Africa continues to record some of the highest adolescent fertility burdens globally (WHO, 2024; Teshale et al., 2025). In Nigeria, recent evidence shows that adolescent pregnancy is not driven by a single cause but by individual, family, school, community and structural factors, including low educational attainment, household poverty, poor sexual and reproductive health knowledge, peer influence, sexual coercion, early marriage and weak implementation of adolescent health policies (Alukagberie et al., 2023; Ayamolowo et al., 2024; Mbulu et al., 2024). Teenage pregnancy is commonly used to describe pregnancy occurring before the age of 20, while the broader public health term adolescent pregnancy refers to pregnancy among girls aged 10-19 years (WHO, 2024). Adolescence is a period of rapid physical, cognitive, emotional and social development, and pregnancy during this period can interrupt schooling, expose girls to stigma and create health needs that differ from those of adult women (Alex-Ojei et al., 2023; Otegbayo et al., 2023).

Teenage pregnancy should therefore be understood as both a reproductive health issue and a development issue (Alukagberie et al., 2023; WHO, 2024). Sexuality education alone may be insufficient when girls face poverty, low parental supervision, gender-based violence, weak negotiating power, poor access to youth-friendly services and fear of stigma when seeking contraception or pregnancy care (Ayamolowo et al., 2024; Isano et al., 2025). Evidence from Nigeria further indicates that existing adolescent sexual and reproductive health policies require stronger funding, implementation and monitoring to reduce adolescent pregnancy effectively (Alukagberie et al., 2023). Recent evidence has replaced older claims that Nigeria is simply among a small list of countries with the highest teenage pregnancy burden. More accurately, Nigeria continues to experience substantial adolescent pregnancy, with scoping evidence reporting prevalence estimates across Nigerian studies ranging from 7.5% to 49.5%, depending on location, study design and study population (Alukagberie et al., 2023). National and subnational differences are important because adolescent pregnancy is shaped by household wealth, education, place of residence, religion, family structure and community context (Alukagberie et al., 2023; Kareem et al., 2023; Mbulu et al., 2024). However, despite the growing body of evidence from different parts of Nigeria, published school-based data from Uturu, Isuikwato Local Government Area, Abia State, remain scarce. This evidence gap limits the availability of locally relevant information needed to guide school health Programs, adolescent reproductive health interventions, and community-based prevention strategies within the area. Uturu was therefore selected for this study because it comprises several public secondary schools serving predominantly rural communities where socio-economic and contextual factors associated with adolescent pregnancy may differ from those reported in other parts of the country.

Pregnant teenagers may face overlapping health, financial, social and emotional challenges. Compared with adult women, adolescent mothers face higher risks of selected pregnancy and birth-related complications, while their babies face increased risks of low birth weight, preterm birth and severe neonatal conditions (WHO, 2024; Teshale et al., 2025). In Nigeria, adolescent mothers may also encounter stigma, delayed care-seeking, family pressure and barriers to respectful maternal health services, which can worsen pregnancy experiences and healthcare utilization (Alex-Ojei et al., 2023). The negative effects of adolescent pregnancy extend beyond the pregnant teenager and her child to the family, school system, community and wider economy. Early childbearing can affect school completion, limit future employment opportunities and reinforce cycles of poverty, especially when girls withdraw from school or receive limited support to return after childbirth (Otegbayo et al., 2023; Boateng et al., 2023). Poverty can also operate as both a risk factor and a consequence, since economically vulnerable girls may have fewer resources for education, reproductive health information and protective family support (Alukagberie et al., 2023; Kareem et al., 2023; Mbulu et al., 2024). Persistent poverty, inadequate sexual and reproductive health knowledge, sexual abuse, weak parent-child communication and peer pressure can contribute to adolescent pregnancy and its intergenerational consequences (Alukagberie et al., 2023; Ayamolowo et al., 2024; Isano et al., 2025). Although these factors have been widely investigated in different settings, their relative contribution varies across communities, highlighting the need for location-specific evidence to support context-appropriate interventions.

The present study therefore sought to determine the prevalence and associated factors of teenage pregnancy among female students in public secondary schools in Uturu, Isuikwato Local Government Area, Abia State.

Specifically, the study aimed to:

1.Determine the prevalence of teenage pregnancy among female students in public secondary schools in Uturu, Isuikwato Local Government Area, Abia State;
2.Assess the level of knowledge of teenage pregnancy and sexual reproduction among the students;
3.Identify the factors associated with teenage pregnancy among the students; and
4.Examine the educational implications of teenage pregnancy among affected students.

The study addressed the following research questions:

1.What is the prevalence of teenage pregnancy among female students in public secondary schools in Uturu, Isuikwato Local Government Area, Abia State?
2.What is the level of knowledge of teenage pregnancy and sexual reproduction among the students?
3.What factors are associated with teenage pregnancy among the students?
4.What educational implications are reported by students who have experienced teenage pregnancy?

METHODOLOGY

Study Design

A cross-sectional descriptive study was conducted among female students in selected public secondary schools in Uturu, Isuikwato Local Government Area, Abia State, Nigeria. A cross-sectional design collects information on study variables at a single point in time and is appropriate for estimating the prevalence of health conditions and describing associated factors within a defined population, although it cannot establish causal relationships (Pérez-Guerrero et al., 2024). This design was considered appropriate because the study sought to determine the prevalence and associated factors of teenage pregnancy among female students without manipulating the study environment.

Study Setting

The study was conducted in Uturu, Isuikwato Local Government Area, Abia State, Nigeria. Uturu is located between latitudes 5.33°N and 6.03°N in the northern part of Abia State. It is bounded by Okigwe to the north and Ebonyi State to the south. The town hosts two tertiary institutions, Abia State University and Gregory University, approximately fourteen public secondary schools, eight primary healthcare centers and two private hospitals. Most deliveries within the community are conducted in primary healthcare centers, with Obiagu Primary Health Centre recording one of the highest annual numbers of facility-based deliveries. Uturu comprises eight major villages, namely Isunabo, Nvuruvu, Obiagu, Ngodo, Onuaku, Akpa, Achara, Ugwuele and Ndundu. Farming is the predominant occupation of the residents, while Christianity is the major religion. The study was conducted in Uturu because there is limited published evidence on teenage pregnancy among school-going adolescents in the area despite its predominantly rural setting. Generating context-specific evidence from the study area was considered important for informing school-based reproductive health interventions and adolescent health Programs.

Study Population

The study population comprised all female students enrolled in the selected public secondary schools in Uturu, Isuikwato Local Government Area, Abia State.

Sample Size Determination

The accessible population for this study comprised all female students enrolled in the five selected public secondary schools in Isuikwato Local Government Area, Abia State. The accessible population was chosen because these students met the inclusion criteria for participation in the study and were readily available during the period of data collection. The distribution of the accessible population across the selected schools is presented in Table 1.

Table 1: Distribution of the Accessible Population of Female Students in the Selected Public Secondary Schools

School	Number of Female Students
Isuikwato High School	520
Uturu Secondary School	380
Acha Secondary Technical School	432
Ahaba Imenyi Secondary School	548
Eluama Secondary School	280
Total	**2,160**

As shown in Table 1, a total of 2,160 female students constituted the accessible population for the study. Among the selected schools, Ahaba Imenyi Secondary School had the highest number of female students (548), accounting for approximately 25.4% of the accessible population. This was followed by Isuikwato High School with 520 students (24.1%), while Acha Secondary Technical School had 432 students (20.0%). Uturu Secondary School contributed 380 students (17.6%), whereas Eluama Secondary School had the smallest female student population, with 280 students (13.0%). The variation in the number of female students across the selected schools demonstrates differences in school enrolment but also provides a broad representation of the study area, thereby enhancing the representativeness of the sample. The sample size was determined using the Taro Yamane (1967) formula for finite populations:

$$n = \frac{N}{1 + N(e)^2}$$

Where:

- n = required sample size
- N = accessible population (2,160)
- e = level of precision (0.0645)

Substituting the values into the formula:

$$n = \frac{2160}{1 + 2160(0.0645)^2}$$
$$= \frac{2160}{1 + 2160(0.00416)}$$
$$= \frac{2160}{9.99}$$
$$= 216.2 \approx 216$$

A precision level of 6.45% was considered appropriate considering the accessible population, available resources, time constraints, and logistical requirements associated with data collection. Consequently, a sample size of 216 respondents was obtained and considered adequate for generating reliable and representative findings for the study. The calculated sample was subsequently proportionately allocated to the five selected schools based on their respective female student populations to ensure that each school was fairly represented in the study.

Sampling Technique

A multistage sampling technique was employed.
In the first stage, five public secondary schools were selected by simple random sampling from the eligible government-owned secondary schools in Uturu. The selected schools were Isuikwato High School, Uturu Secondary School, Acha Secondary Technical School, Ahaba Imenyi Secondary School and Eluama Secondary School. These schools were selected to ensure representation of students from different parts of the study area.
In the second stage, classes were selected across the junior and senior secondary school levels.
In the third stage, eligible female students were selected from the sampled classes using simple random sampling until the required sample size was achieved.

Instrument for Data Collection

Data were collected using a structured questionnaire developed from the objectives of the study and relevant literature on teenage pregnancy. The questionnaire consisted of two sections. Section A obtained information on the socio-demographic characteristics of the respondents, while Section B contained questions on knowledge of teenage pregnancy and sexual reproduction, sexual behavior, associated factors of teenage pregnancy, and its educational implications. The questionnaire was selected because it enabled the collection of standardized information from a relatively large number of respondents within a short period.

Validity of the Instrument

Face and content validity of the questionnaire were established through expert review by specialists in public health and reproductive health. The experts assessed the relevance, clarity and appropriateness of the questionnaire items in relation to the study objectives, and their recommendations were incorporated before the instrument was administered.

Reliability of the Instrument

A pre-test of the questionnaire was conducted among female students in a public secondary school outside the study area. The pre-test was undertaken to assess the clarity, comprehensibility and suitability of the questionnaire items. Feedback obtained during the pre-test was used to revise ambiguous questions and improve the overall quality of the instrument before the main data collection.

Data Collection Procedure

Following ethical approval and permission from the relevant school authorities, the researcher administered the questionnaires to eligible respondents within the selected schools. The purpose of the study was explained to the participants before questionnaire administration. Respondents were instructed to complete the questionnaires independently and privately to encourage honest responses. Completed questionnaires were retrieved immediately after completion to minimize non-response and missing data.

Data Analysis

Completed questionnaires were checked for completeness before data entry and analysis. Data were analyzed using descriptive statistics, including frequencies and percentages, to summarize the socio-demographic characteristics of the respondents, their knowledge of teenage pregnancy and sexual reproduction, sexual behavior, factors associated with teenage pregnancy, pregnancy outcomes, and educational implications. The analyzed data were presented in tables and described narratively to facilitate interpretation of the findings.

Ethical Considerations

Ethical approval for this study was obtained from the Ethics Committee of Abia State University before the commencement of data collection. Administrative permission was also obtained from the principals of the

Table 2: Age Distribution of the Respondents

	No. of respondents (%)					
Age	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
13 years	2(0.9%)	1(0.5%)	4(1.9%)	3(1.4%)	1(0.5%)	**11(5.1%)**
14 years	3(1.4%)	4(1.9%)	1(0.5%)	2(0.9%)	5(2.3%)	**15(6.9%)**
15 years	6(2.8%)	3(1.4%)	5(2.3%)	4(1.9%)	4(1.9%)	**22(10.2%)**
16 years	7(3.2%)	7(3.2%)	9(4.2%)	6(2.8%)	5(2.3%)	**34(15.7%)**
17 years	9(4.2%)	8(3.7%)	10(4.6%)	11(5.1%)	13(6.0%)	**51(23.6%)**
18 years	8(3.7%)	10(4.6%)	14(6.5%)	5(2.3%)	9(4.2%)	**44(20.4%)**
19 years	7(3.2%)	6(2.8%)	12(5.6%)	4(1.9%)	8(3.7%)	**39(18.1%)**
Total	**42(19.4%)**	**39(18.1%)**	**55(25.5%)**	**35(16.2%)**	**45(20.8%)**	**216(100%)**

Table 3: Distribution of the Respondents by Religion

	No. of respondents (%)					
Religion	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Christian	35(16.2%)	33(15.3%)	47(21.8%)	31(14.3%)	39(18.0%)	**185(85.6%)**
Muslin	4(1.9%)	5(2.3%)	6(2.8%)	3(1.4%)	4(1.9%)	**22(10.2%)**
Traditionalist	3(1.4%)	1(0.5%)	2(0.9%)	1(0.5%)	2(0.9%)	**9(4.2%)**
Total	**42(19.4%)**	**39(18.1%)**	**55(25.5%)**	**35(16.2%)**	**45(20.8%)**	**216(100%)**

Table 4: Place of Residence of Students

	No. of respondent (%)					
Residence	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Urban	6(2.8%)	3(1.4%)	2(0.9%)	4(1.9%)	3(1.4%)	**18(8.3%)**
Sub-urban	11(5.1%)	10(4.6%)	9(4.2%)	7(3.2%)	12(5.6%)	**49(22.6%)**
Rural	25(11.6%)	26(12.0%)	44(20.4%)	24(11.1%)	30(13.9%)	**149(70%)**
Total	**42(19.4%)**	**39(18.1%)**	**55(25.5%)**	**35(16.2%)**	**45(20.8%)**	**216(100%)**

selected public secondary schools. Participation in the study was voluntary. The purpose and objectives of the study were explained to the respondents before data collection, and informed consent was obtained from those who agreed to participate. Respondents were informed of their right to decline participation or withdraw from the study at any stage without any consequences. Confidentiality and anonymity were maintained throughout the study by ensuring that no personally identifying information was collected, and all information obtained was used solely for research purposes.

RESULTS

From the table above, majority 51(23.6%) of the respondents were 17 years, followed by those who were 18 years 44(20.4%). Those who were 19 years were 39(18.1%), while those who were 16 years were 34(15.7%). Also, those who were 15 years were 22(10.2%), while those who were 14 years were 15(6.9%). Lastly the least 11(5.1%) respondents were aged 13 years (table 2). Comparatively, from the five schools studied, among respondents were 17 years, ESS had the highest 13(6.0%), while USS had the least 8(3.7%). For those aged 18 years, ASTEC had the highest 14(6.5%), while AISS had the least 5(2.3%) respondents. Those who were 19 years, ASTEC had the highest 12(5.6%), while AISS had the least 4(1.9%). For those who were 16 years ASTEC had the highest 9(4.2%), while ESS had the least 5(2.3%). Also, those who were 15 years, the highest 6(2.8%) were from ISHS, while USS had the least 3(1.4%). Further, those who were 14 years had their highest 5(2.3%) in ESS, while ASTEC had the least 1(0.5%). Lastly the least respondents 13 years, had their highest 4(1.9%) in ASTEC and their least 1(0.5%) in USS and ESS each. From table 3 above, the highest 185(85.6%) respondents were Christians, this was distantly followed by Muslims 22(10.2%) and Traditionalist were the least 9(4.2%) (table 3). Descriptively, among Christians, ASTEC had the highest 47(21.8%), while AISS had the least 31(14.3%). Muslims had their highest 6(2.8%) respondents in ASTEC, while their least 3(1.4%) were in AISS. For those who were traditionalist, ISHS had the highest 3(1.4%), while USS and AISS each had the least 1(0.5%) respondents. The table above shows the place of residence of respondents. The highest 149(70%) respondents lived in rural areas; this was distantly followed by those who lived in sub-urban areas 49(22.6%) and those who lived in urban areas were the least 18(8.3%) (table 4). From the table above, among those who lived in

Table 5: Grade Level of Respondents

	No. of respondent (%)					
Variables	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
JSS1-JSS3	12(5.6%)	16(7.4%)	15(6.9%)	11(5.1%)	17(7.8%)	71(32.9%)
SSS1-SSS3	30(13.9%)	23(10.6%)	40(18.5%)	24(11.1%)	28(13.0%)	145(67.1%)
Total	**42(19.4%)**	**39(18.1%)**	**55(25.5%)**	**35(16.2%)**	**45(20.8%)**	**216(100%)**

Table 6: Respondents' Knowledge of Teenage Pregnancy and Sexual Reproduction

Have Knowledge	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Yes	20 (9.3%)	23 (10.6%)	36 (16.7%)	18 (8.3%)	25 (11.6%)	**122 (56.5%)**
No	22 (10.2%)	16 (7.4%)	19 (8.8%)	17 (7.8%)	20 (9.3%)	**94 (43.5%)**
Total	**42 (19.4%)**	**39 (18.1%)**	**55 (25.5%)**	**35 (16.2%)**	**45 (20.8%)**	**216 (100%)**

Table 7: Sources of Information on Teenage Pregnancy and Sexual Reproduction Among Respondents with Prior Knowledge (n = 122)

Source of Information	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Mother	6	5	9	4	6	30 (24.6%)
Father	1	4	3	2	4	14 (11.5%)
Guardian	4	2	3	1	2	12 (9.8%)
Sibling	2	1	6	4	3	16 (13.1%)
Teacher	4	5	8	2	6	25 (20.5%)
Friends	1	1	3	4	2	11 (9.0%)
Internet	2	5	4	1	2	14 (11.5%)
Total	**20**	**23**	**36**	**18**	**25**	122 (100%)

rural areas, ASTEC had the highest 44(20.4%), while AISS had the least 24(11.1%). Sub-urban dwellers had their highest 12(5.6%) respondents in ESS, while their least 7(3.2%) were in AISS. For those who lived in urban areas, ISHS had the highest 6(2.8%), while ASTEC had the least 2(0.9%) respondents. Majority 145(67.1%) of respondents were in Senior Secondary School 1-3, while those in Junior Secondary School had the least 71(32.9%) (table 5). Table 5 above, for those in SSS 1-3, ASTEC had the highest 40(18.5%) respondents, while AISS had the lowest 11(5.1%). Those in JSS 1-3, ESS had the highest 17(7.8%) while AISS had the least 11(5.1%) respondents.

Knowledge and Effect of Teenage Pregnancy among Students of Teenage Pregnancy among Students

Table 6 shows respondents' knowledge of teenage pregnancy and sexual reproduction. Of the 216 respondents, 122 (56.5%) reported having knowledge of teenage pregnancy and sexual reproduction, whereas 94 (43.5%) reported having no knowledge of the subject. Among the five schools, respondents from ASTEC had the highest proportion reporting knowledge (36; 16.7%), while respondents from AISS had the lowest (18; 8.3%). Table 7 presents the sources of information among the 122 respondents who reported having prior knowledge of teenage pregnancy and sexual reproduction. Mothers were the most commonly reported source of information (30, 24.6%), followed by teachers (25, 20.5%) and siblings (16, 13.1%). Fathers and the internet each accounted for 14 (11.5%) respondents, while guardians and friends accounted for 12 (9.8%) and 11 (9.0%) respondents, respectively. Across the five schools, respondents from ASTEC reported the highest number of those who received information from their mothers (9), siblings (6), and teachers (8), whereas respondents from AISS generally reported the lowest frequencies across most information sources. The table above shows the responses of respondents to teenage pregnancy. Majority 148(68.5%) of the respondents were sexually active and have had sex, while 68(31.5%) respondents didn't have any sexual relations of any kind. Out of those who have had sex previously, 82(55.4%) have gotten pregnant while 66(44.6%) didn't get pregnant (table 8). Examining the table above, from the five schools studied, from those who have had sex, ASTEC had the highest 38(17.6%) respondents, while AISS had the least 21(9.7%). Among those who had gotten pregnant, ESS had the highest 24(16.2%) respondents, while AISS had the least 9(6.1%) respondents (Table 8). The table above shows the age of respondents during pregnancy. Majority 22(26.8%) of the respondents were 17 years, followed by those who were 19 years 16(19.5%). Those who were 18 years were 14(17.1%), while those who were 15 years were 11(13.4%). Also, those who were 16 years were 9(11.0%), while those who were 14 years were 6(7.3%). Lastly the least 4(4.9%) respondents were aged 13 years (table 9). Descriptively, from the five schools studied, among respondents were 17 years, ASTEC had the highest 7(8.5%), while ISHS and AISS each had the least 3(3.7%). For those aged 19 years, ESS had the highest 5(6.1%), while AISS and ISHS had the least 5(2.3%) respondents

Table 8: Respondents' Response to Teenage Pregnancy

	No. of respondent (%)					
Ever had sex	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Yes	27(12.5%)	29(13.4%)	38(17.6%)	21(9.7%)	33(15.3%)	**148(68.5%)**
No	15(6.9%)	10(4.6%)	17(7.9%)	14(6.5%)	12(5.6%)	**68(31.5%)**
Total	**42(19.4%)**	**39(18.1%)**	**55(25.5%)**	**35(16.2%)**	**45(20.8%)**	**216(100%)**
Ever Pregnant						
Yes	11(7.4%)	15(10.1%)	23(15.5%)	9(6.1%)	24(16.2%)	**82(55.4%)**
No	16(10.8%)	14(9.5%)	15(10.1%)	12(8.1%)	9(6.1%)	**66(44.6%)**
Total	**27(18.2%)**	**29(19.6%)**	**38(25.7%)**	**21(14.2%)**	**33(22.3%)**	**148(100%)**

Table 9: Respondents' Age During Pregnancy

	No. of respondent (%)					
Age	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
13 years	1(1.2%)	0(0.0%)	2(2.4%)	0(0.0%)	1(1.2%)	**4(4.9%)**
14 years	0(0.0%)	2(2.4%)	1(1.2%)	1(1.2%)	2(2.4%)	**6(7.3%)**
15 years	3(3.7%)	1(1.2%)	4(4.9%)	0(0.0%)	2(2.4%)	**11(13.4%)**
16 years	1(1.2%)	1(1.2%)	2(2.4%)	2(2.4%)	3(3.7%)	**9(11.0%)**
17 years	3(3.7%)	4(4.9%)	7(8.5%)	3(3.7%)	5(6.1%)	**22(26.8%)**
18 years	1(1.2%)	3(3.7%)	4(4.9%)	1(1.2%)	6(7.3%)	**14(17.1%)**
19 years	2(2.4%)	4(4.9%)	3(3.7%)	2(2.4%)	5(6.1%)	**16(19.5%)**
Total	**11(13.4%)**	**15(18.3%)**	**23(28.0%)**	**9(11.0%)**	**24(29.3%)**	**82(100%)**

Table 10: Pregnancy Outcome of the Respondents

	No. of respondent (%)					
Variables	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Child alive	4(4.9%)	6(7.3%)	11(13.4%)	5(6.1%)	12(14.6%)	**38(46.3%)**
Perinatal death	2(2.4%)	4(4.9%)	5(6.1%)	1(1.2%)	6(7.3%)	**18(22.0%)**
Premature	4(4.9%)	2(2.4%)	5(6.1%)	2(2.4%)	3(3.7%)	**16(19.5%)**
Abortion	1(1.2%)	3(3.7%)	2(2.4%)	1(1.2%)	3(3.7%)	**10(12.2%)**
Total	**11(13.4%)**	**15(18.3%)**	**23(28.0%)**	**9(11.0%)**	**24(29.3%)**	**82(100%)**

each. Those who were 18 years, ESS had the highest 6(7.3%), while AISS and ISHS each had the least 1(1.2%). For those who were 15 years ASTEC had the highest 4(4.9%), while AISS had the least 0(0.0%). Also, those who were 16 years, the highest 3(3.7%) were from ESS, while USS and ISHS each had the least 1(1.2%). Further, those who were 14 years had their highest 2(2.4%) in ESS and USS each, while ISHS had the least 0(0.0%). Lastly the least respondents 13 years, had their highest 2(2.4%) in ASTEC and their least 0(0.0%) in USS and AISS each.

Table 10 shows the pregnancy outcomes of the respondents. 38(46.3%) of the respondents had their child alive, 18(22.0%) had perinatal death, 16(19.5%) had premature birth, and the lowest 10(12.2%) had an abortion. From the five schools studied, from those who had their child alive, ESS had the highest 12(14.6%) while ISHS had the lowest 4(4.9%). Among those who had perinatal death, ESS had the highest 6(7.3%) while AISS had the lowest 1(1.2%). Those who had premature birth, ASTEC had the highest 5(6.1%), while USS and AISS had the least 2(2.4%) respondents each. For those who had an abortion, USS and ESS had the highest 3(3.7%) each while ISHS and AISS had the least 1(1.2%) respondents each. The table above shows the factors influencing teenage pregnancy among the respondents. Majority 24(29.3%) of the respondents were influenced by poverty, 14(17.1%) by peer pressure, 10(12.2%) by sexual abuse, 9(10.9%) by social media, 7(8.5%) by parental divorce/ separation, 6(7.3%) by lack of sex education, 5(6.1%) by physical neglect, 4(4.9%) by drug and alcohol influence, and the least 3(3.7%) out of curiosity (table 11). Assessing the five schools studied, those who were influenced by poverty had their highest 9(10.9%) in ASTEC, and their lowest 2(2.4%) in ISHS. Among those influenced by peer pressure, ESS had the highest 6(7.3%), while ISHS had the least 1(1.2%). Among those sexually abused, ESS had the highest while USS had the least 0(0.0%). For those influenced by social media, ASTEC had the highest 3(3.7%), while AISS had the least 0(0.0%). Those influenced by parental separation/ divorce, ESS had the highest 3(3.7%) while AISS had the least. More so, among those who had no sex education, USS and ESS had the highest 2(2.4%) respondents each, while AISS had the least. Those who were physically neglected, ESS had the

Table 11: Factors That Influenced Teenage Pregnancy among the Respondents.

	No. of respondents (%)					
Variables	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Poverty	2(2.4%)	6(7.3%)	9(10.9%)	3(3.7%)	4(4.9%)	**24(29.3%)**
Peer pressure	1(1.2%)	3(3.7%)	2(2.4%)	2(2.4%)	6(7.3%)	**14(17.1%)**
Sexual abuse	2(2.4%)	0(0.0%)	3(3.7%)	1(1.2%)	4(4.9%)	**10(12.2%)**
Parental divorce/separation	1(1.2%)	1(1.2%)	2(2.4%)	0(0.0%)	3(3.7%)	**7(8.5%)**
Physical neglect	1(1.2%)	0(0.0%)	1(1.2%)	1(1.2%)	2(2.4%)	**5(6.1%)**
Social media	2(2.4%)	2(2.4%)	3(3.7%)	0(0.0%)	2(2.4%)	**9(10.9%)**
Drug abuse/alcohol	0(0.0%)	1(1.2%)	2(2.4%)	1(1.2%)	0(0.0%)	**4(4.9%)**
Lack of sex education	1(1.2%)	2(2.4%)	1(1.2%)	0(0.0%)	2(2.4%)	**6(7.3%)**
Curiosity	1(1.2%)	0(0.0%)	0(0.0%)	1(1.2%)	1(1.2%)	**3(3.7%)**
Total	**11(13.4%)**	**15(18.3%)**	**23(28.0%)**	**9(11.0%)**	**24(29.3%)**	**82(100%)**

Table 12: Responses on the Implication of Teenage Pregnancy

	No. of respondents (%)					
Variables	**ISHS**	**USS**	**ASTEC**	**AISS**	**ESS**	**Total**
Sexually Transmitted Infection	2(2.4%)	5(6.1%)	8(9.8%)	2(2.4%)	9(10.9%)	**26(31.7%)**
Abortion	1(1.2%)	3(3.7%)	2(2.4%)	1(1.2%)	3(3.7%)	**10(12.2%)**
Infertility	2(2.4%)	0(0.0%)	2(2.4%)	1(1.2%)	0(0.0%)	**5(6.1%)**
Withdrawal from school	6(7.3%)	7(8.5%)	11(13.4%)	5(6.1%)	12(14.6%)	**41(50%)**
Total	**11(13.4%)**	**15(18.3%)**	**23(28.0%)**	**9(11.0%)**	**24(29.3%)**	**82(100%)**

Table 13: Academic Performance of Respondents Before and After Pregnancy

	No. of respondents (%)	
Variables	**Before**	**After**
Excellent	25(30.5%)	0(0.0%)
Very good	28(34.1%)	8(9.8%)
Good	16(19.5%)	18(21.9%)
Average	10(12.2%)	21(25.6%)
Below average	3(3.7%)	35(42.7%)
Total	**82(100%)**	**82(100%)**

highest 2(2.4%) while USS had the lowest 0(0.0%). Among those influenced by drugs and alcohol, ASTEC had the highest 2(2.4%), and ISHS and ESS had the least. Lastly those who got pregnant out of curiosity had their highest 1(1.2%) respondents each in ISHS, AISS, and ESS, and their least 0(0.0%) respondents in USS and ASTEC each. The table above shows the implications of teenage pregnancy on the respondents. Majority of the respondents had to withdraw from school 41(50%), 26(31.7%) of the respondents contacted sexually transmitted infection, 10(12.2%) had an abortion, 5(6.1%) became infertile (table 12). Observing the five schools studied, among those who withdrew from school, ESS had the highest 12(14.6%) respondents, while AISS had the least 5(6.1%). Those who contacted sexually transmitted infection, ESS had the highest 9(10.9%), ISHS had the least 2(2.4%). Those who did abortion, USS and ESS had the highest 3(3.7%) each, while ISHS and AISS each had the lowest 1(1.2%) respondents. The least respondents, who infertile, ISHS and ASTEC each had the highest, while the least 0(0.0%) were from USS and ESS. Table 13 presents respondents' self-reported academic performance before and after pregnancy. Before pregnancy, the largest proportion of respondents reported performing very well academically (28, 34.1%), followed by those who reported excellent performance (25, 30.5%). Sixteen (19.5%) respondents reported good performance, 10 (12.2%) reported average performance, and only 3 (3.7%) reported performing below average. Following pregnancy, respondents most commonly reported below-average academic performance (35, 42.7%), while none reported maintaining excellent academic performance. Twenty-one (25.6%) respondents reported average performance, 18 (21.9%) reported good performance, and 8 (9.8%) reported very good performance. These findings are based on respondents' retrospective recall of their academic performance before and after pregnancy and should therefore be interpreted as self-reported perceptions rather than objectively measured longitudinal changes in academic performance.

DISCUSSION OF FINDINGS

Results on Socio-Demographic Distribution of Respondents

The primary objective of this study was to determine the prevalence of teenage pregnancy and identify the factors associated with teenage pregnancy among female students in public secondary schools in Uturu, Isuikwato Local Government Area, Abia State. The findings indicated that respondents aged 17 years constituted the largest age group (51, 23.6%). Among the five schools studied, Eluama Secondary School (ESS) had the highest number of respondents in this age group (13, 6.0%), while Uturu Secondary School (USS) had the lowest (8, 3.7%). The findings showed that Christians formed the largest religious group in the study. Acha Secondary Technical School (ASTEC) had the highest number of Christian respondents 47(21.8%), while Ahaba Imenyi Secondary School (AISS) had the least 31(14.3%). The pattern is consistent with the local setting of Uturu, where Christianity is common, but religion should not be interpreted alone because Nigerian evidence shows that adolescent pregnancy is shaped by the combined effects of household wealth, education, residence, family and community factors (Alukagberie et al., 2023; Kareem et al., 2023; Mbulu et al., 2024).

The findings showed that rural dwellers formed the largest residential group. ASTEC had the highest number of rural dwellers 44(20.4%), while AISS had the least 24(11.1%). The rural pattern is important because recent Nigerian evidence indicates that adolescent pregnancy may be influenced by household and community-level conditions, including rural residence, household structure, wealth and access to information and services (Alukagberie et al., 2023; Kareem et al., 2023; Mbulu et al., 2024). The findings showed that students in SSS1-SSS3 formed the largest grade-level group. ASTEC had the highest number of respondents in SSS1-SSS3 40(18.5%), while USS had the least. Senior secondary school students may be more exposed to puberty-related sexual development, peer influence and relationship pressures than younger students, making age-appropriate reproductive health education important before and during senior secondary school (Panda et al., 2023; Isano et al., 2025).

Results on Knowledge and Effect of Teenage Pregnancy among Students of Teenage Pregnancy among Students

The findings showed that 94(43.5%) respondents had no knowledge of teenage pregnancy and sexual reproduction. ISHS had the highest number of respondents who reported no knowledge, while USS had 16(7.4%). Mothers were the most commonly reported source of information among those who had knowledge. Inadequate sexual and reproductive health knowledge remains a key concern because misconceptions about fertility, contraception and pregnancy prevention can increase vulnerability to unintended pregnancy, especially where adolescents fear stigma or lack access to youth-friendly services (Panda et al., 2023; Ayamolowo et al., 2024). Recent evidence emphasizes that supportive parent-child communication and family connection can protect adolescents, while poor communication, weak supervision, parental neglect and unstable home environments may increase vulnerability to risky sexual behavior and early pregnancy (Boateng et al., 2023; Adhena & Fikre, 2023). Parent-child discussions about sexuality are therefore relevant in Uturu because many respondents identified mothers as the main source of information, while a large proportion still reported no knowledge of teenage pregnancy and sexual reproduction. The findings showed that 148(68.5%) respondents were sexually active and 82(55.4%) of those who had ever had sex had become pregnant. ASTEC had the highest number of sexually active respondents, while ESS had the highest number of respondents who had been pregnant. Early sexual initiation, low contraceptive knowledge, peer pressure, confidentiality concerns and limited access to adolescent-responsive sexual and reproductive health services have all been associated with adolescent pregnancy in recent studies (Ayamolowo et al., 2024; Isano et al., 2025).

The findings showed that respondents aged 17 years formed the largest group among those who had been pregnant 22(26.8%). ASTEC had the highest number in this age category. Late adolescence is a period when sexual relationships, peer influence and reproductive decision-making may become more prominent, and studies across sub-Saharan Africa show that adolescent pregnancy risk is closely linked to schooling status, sexual debut, family context and reproductive health knowledge (Nshimiyimana et al., 2025; Isano et al., 2025). Regional evidence also shows that pregnancy risk increases when adolescents lack accurate reproductive health information, are out of school or have limited family support. In a study among adolescent girls in a refugee setting, not attending school and family history of teenage pregnancy were associated with early pregnancy, while another study in Rwanda found that formal sexual and reproductive health education was associated with reduced pregnancy risk (Adhena & Fikre, 2023; Isano et al., 2025). The findings revealed that 38(46.3%) respondents had a living child, while perinatal death 18(22.0%), premature birth 16(19.5%) and abortion 10(12.2%) were also reported. Adolescent pregnancy is clinically important because recent sub-Saharan African evidence links teenage pregnancy with higher adverse birth outcomes, including preterm birth, stillbirth and low birth weight (Teshale et al., 2025; WHO, 2024).

The findings showed that poverty was the leading reported factor influencing teenage pregnancy 24(29.3%), followed by peer pressure 14(17.1%), sexual abuse 10(12.2%) and social media 9(10.9%). The prominence of poverty is consistent with recent Nigerian evidence

identifying wealth index and educational attainment as major factors associated with adolescent pregnancy, while regional studies also show that poverty, parental neglect, peer pressure and limited family planning knowledge can contribute to repeat or early teenage pregnancies (Alukagberie et al., 2023; Boateng et al., 2023; Mbulu et al., 2024).

The findings showed that withdrawal from school was the most common implication of teenage pregnancy 41(50%). ESS had the highest number of withdrawals, while AISS had the least. School withdrawal is a serious consequence because it can reduce educational attainment, limit future employment prospects and increase economic dependence, while recent Nigerian research has shown that teenage pregnancy disrupts girls' academic development and can worsen long-term socioeconomic vulnerability (Otegbayo et al., 2023; Alukagberie et al., 2023). The study also observed a major decline in academic performance after pregnancy. Before pregnancy, 28(34.1%) respondents performed very well and 25(30.5%) were excellent, while after pregnancy 35(42.7%) were below average and none remained excellent. The finding aligns with evidence that pregnancy during schooling can reduce concentration, attendance, performance and continuation in school, especially when schools and families lack reintegration support for pregnant and parenting adolescents (Otegbayo et al., 2023).

Limitations of the Study

This study has some limitations that should be considered when interpreting the findings. First, the cross-sectional design limits the ability to establish causal relationships between the identified factors and teenage pregnancy. Second, although a multistage sampling technique was employed, the study was conducted in five selected public secondary schools in Uturu, which may limit the generalizability of the findings to all adolescents within Isuikwato Local Government Area and other settings. Third, information on sexual behavior, pregnancy history, and academic performance before and after pregnancy was based on respondents' self-reports and retrospective recall, making the findings susceptible to recall and social desirability bias. Fourth, although the questionnaire was pre-tested before data collection, a quantitative reliability coefficient was not determined. Finally, the study primarily employed descriptive statistics; therefore, the findings describe patterns observed among the respondents and do not establish statistically significant associations between study variables.

Suggestions for Further Studies

Future studies should employ larger and more representative samples drawn from multiple local government areas or states to improve the generalizability of the findings. Analytical studies incorporating inferential statistical techniques, such as chi-square tests and multivariable analyses, are recommended to identify factors independently associated with teenage pregnancy. Longitudinal studies are also needed to better understand the temporal relationship between associated factors and teenage pregnancy, while future research should consider using objective academic records to complement self-reported educational outcomes.

Conclusion

This study achieved its objective of determining the prevalence and associated factors of teenage pregnancy among female students in public secondary schools in Uturu, Isuikwato Local Government Area, Abia State. The findings showed that teenage pregnancy was common among the respondents and was frequently reported alongside factors such as poverty, inadequate knowledge of sexual and reproductive health, peer pressure, and sexual abuse. Respondents who had experienced teenage pregnancy also reported educational challenges, particularly school withdrawal and poorer academic performance.

Overall, the findings suggest that teenage pregnancy remains an important public health, educational, and social concern in the study area. Addressing this challenge requires comprehensive interventions that combine age-appropriate school-based sexuality education, strengthened parent-child communication, adolescent-responsive sexual and reproductive health services, poverty-sensitive support Programs, and effective measures to prevent sexual abuse and exploitation among adolescents.

Recommendations

Based on the findings of this study, the following recommendations are made:

1.Schools should strengthen the delivery of age-appropriate comprehensive sexuality education to improve students' knowledge of puberty, reproductive health, contraception, sexually transmitted infections, consent, healthy relationships, and informed decision-making.
2.Parents and guardians should be encouraged to maintain open and supportive communication with adolescents on sexual and reproductive health issues to promote informed decision-making and reduce misinformation.
3.Government and healthcare providers should strengthen adolescent-responsive sexual and reproductive health services by ensuring that young people have access to confidential counselling, accurate reproductive health information, appropriate contraceptive services, and timely referral where necessary.
4.Community-based Programs should address broader social and economic factors associated with teenage pregnancy, including poverty, peer influence, sexual

abuse, and limited access to reproductive health information. These interventions should actively involve parents, teachers, religious leaders, community leaders, health workers, and youth organizations.

5.Schools and communities should strengthen child protection mechanisms by promoting awareness of sexual abuse, establishing confidential reporting systems, and ensuring appropriate referral and support services for vulnerable adolescents.

6.Policies should support pregnant and parenting adolescents to remain in school or return to school after childbirth through counselling services, anti-stigma initiatives, academic support, and flexible educational opportunities.

7.Further studies should employ analytical and longitudinal research designs to provide a better understanding of the factors associated with teenage pregnancy and to evaluate the effectiveness of interventions aimed at reducing its occurrence among adolescents.

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