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Original Research Article

The influence of cultural practices and socioeconomic factors on teenage pregnancy across selected primary health care centers in Akinyele local government area, Ibadan, Nigeria

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ABSTRACT

Background: Teenage pregnancy is a significant contributor to maternal and child mortality and a driver of the cycle of ill health and poverty, particularly in low- and middle-income countries (LMICs). Globally, around 21 million girls aged 15-19 and 2 million under 14 give birth annually, with 95% of these births occurring in developing countries. In Nigeria, the burden of teenage pregnancy is exacerbated by cultural practices, socioeconomic challenges, and limited access to education and reproductive health services.
Methods: A cross-sectional study was conducted across selected primary health care (PHC) centers in Akinyele local government area (LGA), Ibadan, Nigeria. Twelve PHCs were randomly selected, one from each ward. A multi-stage sampling method was used to select teenage antenatal attendees. A sampling frame was developed from antenatal records, and eligible participants were chosen using computer-generated random numbers. Data were collected using a validated questionnaire with both open- and close-ended questions from July to August 2024. Statistical analysis was done using IBM SPSS version 27.0, with significance set at $p \leq 0.05$.
Results: Peer pressure (58.5%) and family pressure (46.5%) were the most reported causes of teenage pregnancy. Cultural barriers around sex education and contraception were reported by 80.3% of participants, with only 9.4% affirming open dialogue. Financial hardship and lack of educational opportunities were also cited by 78.7% as key contributing factors. The mean age of respondents was 17.5 years (SD±1.57).
Conclusions: Cultural and socioeconomic factors significantly influence teenage pregnancy, highlighting the urgent need for targeted interventions in education, family engagement, and reproductive health communication.

Keywords: Teenage pregnancy, Cultural practices, Socio-economic factors

INTRODUCTION

The United Nations children's fund (UNICEF) characterizes teenage pregnancy as conception occurring between the ages of 13 and 19 years.[1] In colloquial language, the term teenage pregnancy typically refers to young women who become pregnant before attaining legal adulthood, with the age of majority differing globally. Moreover, the terms adolescent, young person, and youngster are sometimes employed interchangeably with

the term teenager, despite their distinct definitions. Annually, around 21 million adolescent females aged 15 to 19 years' experience pregnancy in LMICs.[2]

The incidence of teenage pregnancy constitutes a significant public health issue. The bulk of fatalities among pregnant adolescents transpire in LMICs.[3] Worldwide, adolescent pregnancy constitutes a significant public health issue. The predominant cause of mortality among adolescent females is associated with pregnancy and childbirth, with 99% of all maternal deaths in this demographic occurring in PHC.[4,5] Consequently, the choices an individual takes in response to the opportunities available throughout this pivotal developmental stage are essential for fostering a healthy adult existence. The prevalence of teenage pregnancy is regarded as a societal concern that differs markedly between industrialized and developing nations. [6] More than 90% of these instances arise in low- and middle-income nations, particularly in Bangladesh, Brazil, the Democratic Republic of Congo, Ethiopia, India, Malawi, and Nigeria. The 2018 demographic health study by the national population commission of Nigeria (NPCN) indicates that prevalence of teenage pregnancy ranges from 7.5% to 49.5%.

Approximately 44% of Nigerian girls marry before turning 18, ranking Nigeria as the 11th highest country for child marriage globally.[7] The country has 400,000 unintended births annually, with half occurring among youths aged 14 to 19 years.[8] Teenage mothers often discontinue their education, and by age 22, approximately 38% have completed their secondary schooling. Many lack the requisite qualifications for improved employment opportunities, ultimately compelling them to accept low-paying jobs or, in dire circumstances, remain unemployed due to insufficient parental involvement and oversight. These young women not only abandon their studies but also frequently fall victim to substance abuse, including drug addiction and excessive alcohol drinking.

Teenage pregnancy is a significant societal issue, particularly in Sub-Saharan Africa. Nigeria has had an increase in adolescent pregnancies during the COVID-19 pandemic.[3] The rise in teenage pregnancy instances is not confined to Nigeria; numerous countries are grappling with this issue due to a shift in lifestyle during this period. Young girls who discontinue their schooling due to pregnancy experience a significant interruption in their studies, often struggle to manage their academic responsibilities, and typically rely on their parents and guardians for support.[9] Teenage pregnancy has historically been a problem for numerous nations, as it is associated with more adverse pregnancy outcomes for both the mother and the child compared to adult females.[10,11]

In Ethiopia, prevalence of teenage pregnancy is attributed to inadequate contraception use and insufficient sex education.[12] Authors indicated that girls from low-income homes are more susceptible than those from middle and upper-class families, as their parents often fail to supply essential items, such as hygiene supplies for girls.[13] Study revealed that elevated rates of drug and substance abuse were believed to influence incidence of adolescent pregnancy as illicit substances often impair judgement and increase likelihood of young females engaging in unprotected sexual intercourse with older men.[14]

A demographic health survey done in 2018 by the NPCN indicates that the prevalence of teenage pregnancy ranges from 7.5% to 49.5%. Adolescents facing unexpected pregnancies may endure significant emotional distress due to societal judgement; yet, this attitude has minimally impacted the prevalence of unintentional pregnancies among Nigerian teenagers.[15] Teenage pregnancy is the primary cause of mortality among girls worldwide, with one million adolescent girls dying or experiencing injuries, illnesses, or diseases annually due to pregnancy or childbirth.[16] Pregnancy-related fatalities among adolescents aged 15-19 are twice as prevalent as those among women in their twenties. Teenage pregnancy has significant long-term societal repercussions for girls, boys, families, and communities, resulting in diminished educational achievement, increased high school dropout rates, poor health outcomes, and poverty among adolescents.[17] Moreover, offspring of adolescent mothers are more prone to health complications, encounters with law enforcement throughout adolescence, lower high school graduation grades, teenage pregnancies, and unemployment in young adulthood.[18]

Research on the protective and risk factors for adolescent pregnancy in middle- and low-income nations indicates that individuals with lower socioeconomic level and inadequate education generally exhibit elevated pregnancy rates.[19,20] Teenage pregnancies and births result from various factors; UNICEF estimates indicate that as of 2019, there were 650 million child brides globally. Consequently, it is crucial to recognize that girls who marry at a young age typically possess diminished agency in decisions regarding the postponement of childbearing and the utilization of contraceptives, thereby elevating their risk of pregnancy.[20] Secondly, motherhood is esteemed, and women have limited access to education and employment prospects. Teenagers who access contraceptives may face stigma.[21]

Teenage pregnancy is an undesirable occurrence that seems to be predominantly a societal issue impacting numerous countries, including Nigeria. Teenage pregnancy deprives females of the opportunity to realize their full potential. Regulating adolescent pregnancy yields substantial macroeconomic advantages, including a controllable population increase and enhanced governance for sustainable development.[22] The strategy for managing adolescent pregnancy within the sustainable development goals (SDG) framework incorporates a specific indicator for its prevention. This includes indicator 3.7.2, which measures the birth rate of adolescents aged 10-14 and 15-19 years per 1,000 women in those age brackets, recorded at 5.3.1, representing the proportion of women married

before age of 18. Attaining favorable health outcomes over one's lifespan and fulfilling sustainable development goals related to maternal and neonatal health relies on prevention of adolescent pregnancy and the reduction of associated mortality and morbidity.[23] There is a notable scarcity of studies examining teenage pregnancy that primarily address cultural practices and socioeconomic factors affecting mothers, pregnant adolescents, and unmarried pregnant teenagers, with the aim of enhancing prevention programs through the provision of contemporary program implementation and informed decision-making. This study aims to examine the impact of cultural practices and socioeconomic factors on the incidence of teenage pregnancy through selected PHC centers.

METHODS

This study was a descriptive cross-sectional study conducted over a two-month period, from July-2024 to August-2024, at selected PHC centers in Akinyele LGA, Ibadan, Nigeria.

The study population consisted of pregnant teenagers and teenage mothers aged 13 to 19 years who were able to understand the context of the questionnaire and provided informed consent. Non-consenting teenagers were excluded from the study.

A multi-stage sampling technique was employed to select participants. First, twelve PHCs were randomly selected through balloting from the twelve wards in Akinyele LGA namely Ikereku, (Olanla/Oboda/Labode), (Arulogun/Eniosa/Aroro), (Olode/Amosun/Onidundun), (Ojo-Emo/Moniya), (Akinyele/Isabiyi/Irepodun), (Iwokoto/Talonta/Ido-Oro), (Ojoo/Ajibode/Laniba), (Ijaye/Ojedeji), (Ajibade/Alabata/Elekuru), (Olorisa-Oko/Okegbemi/Mele) and Iroko. At each selected PHC, a sampling frame was developed from the antenatal clinic records during each visit. The sample size was calculated using the Kish and Leslie method (1965), resulting in a required sample of at least 114 participants, with 10% attrition rate factored in, making the final sample size 124.

$n_0=Zx^2PQ/d^2= (1.96)^2\times0.08\times0.92/(0.05)^2$

=114+10% attrition

Where n_0 (sample size)=124 healthcare providers, d=precision=0.05, p=estimated prevalence of teenage pregnancy in South-West Nigeria=8% (Nwosu, 2017), Z=confidence level set at 1.96 at 95% CI, and Q=1-p.

A semi-structured, self-administered questionnaire was used for data collection. The questionnaire was in English and in Yoruba, for participants who did not understand English. The questionnaire included both open- and close-ended questions and was pretested at a different site. Modifications were made based on the pretest results. The instrument collected data on demographics, obstetric history, and socioeconomic and cultural factors.

All participants and their guardians were counseled on the purpose and procedure of the study. Written informed consent was obtained from each participant prior to enrolment. Trained research assistants facilitated the data collection in safe and private spaces to ensure participant comfort and confidentiality. Participants were assured that participation was voluntary, and non-participation would not result in any penalties.

Ethical approval for the study was obtained from the institutional ethics committee and ministry of health. Confidentiality of all participant information was strictly maintained throughout and after the study. Data were analyzed using IBM SPSS for Windows version 27.0. Descriptive statistics, including frequency distributions, tables, and charts, were used to summarize the variables. Cross-tabulations and chi-square tests were used to assess associations between categorical variables. A $p<0.05$ was considered statistically significant.

RESULTS

This study examined the influence of cultural practice and socioeconomic factors on teenage pregnancy across selected PHC centers in Akinyele LGA Ibadan, 124 participants responded to the study. Table 1 shows the socio-demographic characteristics of respondents. More than half (51.2%) of the respondents were Muslims followed by Christianity (48.0%) and only one respondent (0.8%) reported being a traditionalist. On the issue of marital status, most (59.1%) were living with a partner, (21.3%) were single and (19.7%) were in a relationship. About two-fifths (39.4%) were aged 19, (20.5%) aged 18, (13.4%), 17 and the least (5.5%) being 14 years old and with a mean age of 17.5 years old (SD±1.57).

Similarly, about half (47.2% and 46.5%) were self-employed, trader, and artisan and unemployed or student, with only 4.7% and 1.6% having private or government employment (Table 2). Among those engaged in business or employed (n=38), only one respondent earns between ₦71,000-₦80,000, per month with higher percentage falling between ₦10,000-₦20,000 and ₦21,000-₦30,000 per month respectively. The respondent's level of education before pregnancy indicated that (48.8%) had finished senior secondary education, (30.7%) had completed junior secondary education, with just (1.6%) currently having tertiary education experience.

During time of data collection (64.6%) were still staying or leaving with their both parents, while (81.1%) and (74.8%) have a mother and a father, respectively. Of these, about half (48.0%) has a father with 2 or more wives/step-mothers. On average, respondent has about 5 siblings (4.94; SD±1.98) from same biological parents. Surprisingly, (60.6%) had between 4-6 siblings, with over 2/3rd (66.9%) being either 1st, 2nd/3rd child (Table 1).

Evidence from the results showed that those who still have either a father (95, 74.8%) or a mother (103, 81.1%) has

8.7% and 16.5% unemployed parents (Father, and mother respectively); 54.3% and 60.6% were self-employed/trader/artisan parents, with just 8.7% and 7.1%, and 12.6% and 7.1% being private or government employees (Figure 1) (Table 2).

As evidenced in Table 2, about half of the respondents (46.5%) reported feeling pressured by family to marry or have a child at their age, while more than half (53.5%) expressed the opposite. Most (58.3%) indicated that they felt pressured by friends to have a child. With respect to cultural attitudes towards discussions on sex and contraception, a very few (9.4%) of the respondents felt that their culture encourages open dialogue about these topics, while majority (80.3%) believed it does not. Similarly, (92.1%) indicated that their family does not foster or encourage open conversations about sex and contraception, only 6.3% reported that such conversations are encouraged. About a quarter (22.8%) reported that there are cultural or religious beliefs that discourage contraceptive use. Hence, only (12.6%) reported practicing a religion that encouraged open conversations about sex and contraception.

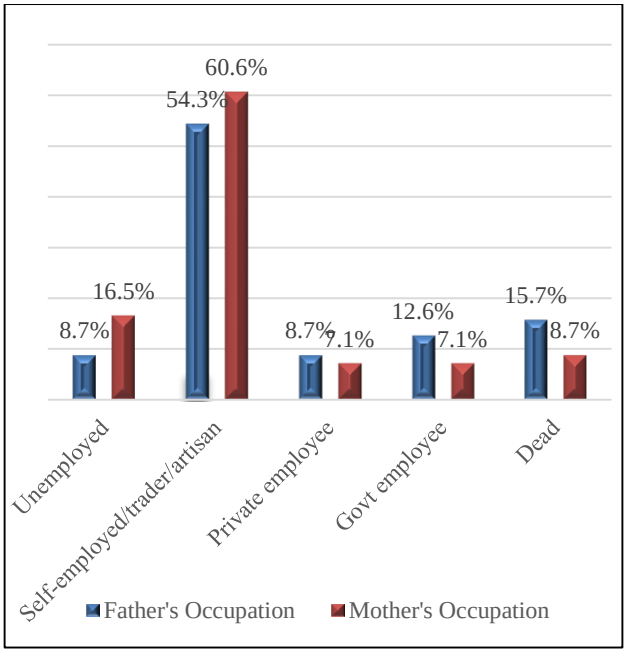

Figure 1: Respondent's parents' types of occupation.

Table 1: Socio-demographic characteristics of respondents, (n=127).

Socio-demographic characteristics	N	Percentages (%)
Religion		
Christianity	61	48.0
Islam	65	51.2
Traditional	1	0.8
Marital status		
Single	27	21.3
Married/living with partner	75	59.1
In a relationship, not married	25	19.7
Age (in years)		
14	7	5.5
15	11	8.7
16	16	12.6
17	17	13.4
18	26	20.5
19	50	39.4
Occupation		
Unemployed or student	59	46.5
Self-employed or trader or artisan	60	47.2
Private employed	6	4.7
Govt employed	2	1.6
Both parents staying together		
Yes	82	64.6
No	45	35.4
Father has more than one wife		
Yes	61	48.0
No	66	52.0
Father still alive		
Yes	95	74.8
No	32	25.2
Mother still alive		
Yes	103	81.1
No	24	18.9

Continued.

Socio-demographic characteristics	N	Percentages (%)
No. of children from both parent		
Between 1-3	28	22.0
4-6	77	60.6
7-9	18	14.2
10-12	4	3.1
Position of respondent in the family		
Between 1-3rd	85	66.9
4-6th	36	28.3
7-9th	5	3.9
10-12th	1	0.8
Education level		
No formal		5.0
Primary		15.0
Junior secondary		30.7
Senior secondary		47.7
Tertiary		1.6

Table 2: Prevailing cultural influences, (n=127).

Variables	Yes, N (%)	No, N (%)	Not sure, don't know, N (%)	Total, N (%)
I felt pressured from my family to marry or have a child at my age	59 (46.5)	68 (53.5)	0 (0.0)	100 (100)
I felt pressured from friends to have a child at my age	74 (58.3)	52 (40.9)	1 (0.8)	100 (100)
My culture encourages open conversations about sex and contraception	12 (9.4)	102 (80.3)	13 (10.2)	100 (100)
My family encourages open conversations about sex and contraception	8 (6.3)	117 (92.1)	2 (1.6)	100 (100)
There are cultural or religious beliefs that discouraged use of contraception among teenagers	29 (22.8)	73 (57.5)	24 (18.9)	100 (100)
My religion encourages open conversations about sex and contraception	16 (12.6)	102 (80.3)	9 (7.1)	100 (100)
My community have rituals or ceremonies that mark the transition to adulthood	5 (3.9)	93 (73.2)	29 (22.8)	100 (100)
Having a child at my young age is a sign of beauty and femininity in my culture/religion	32 (25.2)	90 (70.9)	5 (3.9)	100 (100)
There cultural expectations for young people to marry early in your community	29 (22.8)	77 (60.6)	21 (16.5)	100 (100)
Presence of specific cultural practices/traditions in community that influenced teenage pregnancy	9 (7.1)	93 (73.2)	25 (19.7)	100 (100)
Examples of cultures				
Ceremonies (naming, birthday, end-of-year event)	5 (3.9)	122 (96.1)	0 (00)	100 (100)
Carnival	1 (0.8)	126 (99.2)	0 (00)	100 (100)
High financial expectations from girl child	1 (0.8)	126 (99.2)	0 (00)	100 (100)
	Accepting	**Disapproving**	**Neutral**	**Don't know**
Family view of teenage pregnancy	54 (42.5)	62 (48.8)	10 (7.9)	1 (0.8)
Culture view of teenage pregnancy	36 (28.3)	68 (53.5)	14 (11.0)	9 (7.1)
	Positive	**Neutral**	**Negative**	**Not sure/ don't know**
Prevailing cultural attitudes towards teenage pregnancy in the community	35 (27.6)	23 (18.1)	53 (41.7)	16 (12.6)
	Significant impact	**Some impact**	**Little to no impact**	**Unsure**
How do gender roles in your community affect teenage pregnancy	14 (11.0)	41 (32.3)	29 (22.8)	43 (33.9)

DISCUSSION

This study aimed to understand and identify the influence of cultural and socioeconomic factors on teenage pregnancy across selected PHC centers. The main findings of the study reviewed that more than half of the respondents were Muslims (51.2%) and it was closely followed by Christianity (48%) while only one respondent was reported being a traditionalist. More than half of the respondents reported staying together with their partners (59.1%) which is one of the factors that predisposes them to getting pregnant at a tender age. In this study it has been discovered that religion was an organization component contributing to adolescent pregnancy in Nigeria, despite the move of integrating comprehensive sexual education into schools the implementation is still challenging since some of its components like contraceptives and sexual education may be in opposition to the views of some nation's religious communities. This is in agreement with the study that was looking at the influence of social economic factors of teenage pregnancy, reviewed that due to their propensity for early marriage and potential resistance to contraceptive education, Muslim girls are more likely to became pregnant as adolescents, as young people's sexual behaviors are influenced by the beliefs and the teachings of their respective religion.[24] The rrespondent's level of education before pregnancy indicated that most had finished senior secondary education (48.8%) and (30.7%) completed junior secondary with only (1.6%) reaching tertiary education experience which is contradicting with the study looking at factors associated to teenage pregnancy and child bearing, reviewed that in Nigeria adolescent pregnancy is significantly correlated with educational attainment. It was reported that adolescent pregnancy is common among primary school students than among secondary school students.[25]

Teenagers in Nigeria with higher levels of education can postpone having children and get married later because they have greater access to resources and information.[26] Poor sexual and reproductive health outcomes are caused by lack of information about reproductive health and habits, which is correlated with low levels of education. Factors such as inadequate sex education, the price and accessibility of birth control all contribute to teenage pregnancy, and child bearing this is also in agreement with this study.

According to the findings in the study (64.6%) of respondents were still staying with their both parents while (81%) and (74%) only stay with mother or father respectively, and of these (48.0%) reported having a father who has two or more wives (stepmothers) and an average respondent has about 5-6 siblings from the same biological parents and respondents being either first, second or third born. It is significant to note that parental support can help prevent teenage pregnancy.[27] Ineffective parenting and parental neglect frequently lead to lack of guidance and communication around issues related to sexual and reproductive health, teenagers are left open to false information from their peers and other sources as a result they end up indulging in unsafe sexual and unwanted pregnancies.[28] Parents may put the family's financial interest ahead of raising and guiding their girl children which can result in neglect and greater peer pressure.[29] Additionally, parental advice and counselling can offer a secure and encouraging setting for teenagers to talk about sexual and reproductive health concerns and get correct information.

In certain parts of the country the prevalence of adolescent pregnancy has decreased as a result of improved community awareness and parental supervision.[30,31] These finding are in line with the study titled 'Regional trends and socioeconomic predictors of adolescent pregnancy in Nigeria, it reviewed that single parenting is linked to teenage pregnancy in Nigeria especially in households with a male head which also a factor that has been identified in our study, a high proportion of respondents reported being raised by single parents and stepmothers.[30] It was discovered that teenage pregnancy is more common in homes headed by men, maybe as a result of their inability to establish trust, have delicate conversations with teenage girls about their sexuality, and alert them about potential risk therefore, it is crucial to include male family heads in programs related to family planning and adolescent reproductive health in order to better understand and assist their daughters in these areas.

Findings on the prevailing cultural influence of teenage pregnancy about (46.5%) of respondent reported feeling pressured by family to marry or have a child at their age while more than half expressed the opposite and most of them (58.3%) indicated that they felt pressured by their friends to have a child. Peer pressure has been identified as a significant contributor of teenage pregnancy.[33] The findings show that teenagers are frequently impacted by their peers, who act as socialization facilitators and mold their views and actions around sex. This might normalize and promote dangerous sexual behaviour in teenagers. Furthermore, some teenagers think that having sex is a casual behaviour and that those who don't have sex are strange. Peer pressure typically encourages this conception, which can raise the rate of teenage pregnancies.

On issues of cultural attitude towards sex and contraceptives a very few (9.4%) of the respondents felt that their culture encourages open dialogue about the topics while the majority 80.3% said that it does not encourage open dialogue about sex and contraceptives. Similarly, 92.1% indicated that their families do not foster or encourage open conversations about sex and contraceptives. Similar with the study conducted, indicated that young women did not talk about sex at home even with their mothers or anybody else because they were afraid of being beaten or because it was embarrassing.[34] Only one girl in this study indicated having talked to her mother about sex and another girl said she talked to her

friends about it. Some studies in Sub–Saharan Africa have found significant barriers of communication about sex parents are reluctant to discuss more than the adverse consequences of sexual activity and maternal complications.[35]

On the other hand, (22.8%) expressed that having a child at their age is a sign of beauty and there are cultural expectations for young people to marry early and a few of them affirmed that there is a presence of specific cultural practices or traditions in their community that influence teenage pregnancy. Data on prevailing cultural attitudes towards teenage pregnancy indicated that only (27.6%) of teenagers view it positively and more than half see it as negative or bad attitude. The respondents expressed that gender roles in the community have some impact on teenage pregnancy.

The study further found out that almost half of the respondent acknowledged that the level of education contributes to teenage pregnancy where (48.0%) disagreed with only (4.7%) being uncertain about this. Parents specific education attainment was reported to affect teenage pregnancy issue (44.1%) almost half (48.8%) remained unconvinced about it. Interestingly, the majority (80.3%) affirmed that parents without specific job or occupation contribute significantly to the chances of adolescents becoming pregnant with only (17.3%) disputes this assertion. The majority (78.0%) affirmed that family socioeconomic hardships play a crucial role in the prevalence of teenage pregnancy in any given community.

There is a general consensus among respondents on the implications of teenage socioeconomic status as a cause of early pregnancy, as almost all confirmed that it is attributed to this likelihood of teenagers becoming pregnant. The majority (91.3%) and (94.5%) also agreed that peer pressure and lack of unavailability of employment affects or has great influence on decision making related to teenage pregnancy. Surprisingly, only (18.1%) of respondents felt that there is inadequate access to sexual and reproductive health services. For teenage mothers the majority disagreed with this.

In summary, majority (78.7%) also disagreed to the assertion of sufficient support, financial, education and economic with only (12.6%) affirming its sufficient support. When examining individual behaviors as related to ability to afford or buy contraceptives such as female or male condoms, pills etc. (49.6%) of respondents stated that they could afford contraceptives where (47.2%) that they could not. About two fifths, (37.8%) reported experience of forced or coerced, raped by boyfriend sex lovers and (39.4%) affirmed for being in transaction sex for (money, gifts, support). The consumption of substances as tobacco and alcohol appeared receiving low, as (10.2%) and (26.0%) of respondent respectively reported usage. However, majority (78.7%) have access or listen to radio, television or read newspapers. In their opinion, only (26%) respondents view teenage pregnancy to be positive with over two-fifth (42%) expressing it to be a negative or bad experience however (23%) still had a natural view on this matter. Efforts to curb teenage pregnancy or providing support to teen mothers by community leaders, elders has not been substance, only 10.2% has been reported to be very involved. 21.3% has been somewhat involved where over a half has not taken any practical steps to support towards this.

Limitations

The study's shortcomings include its reliance on self-reported data, which may have led to biases in recollection and social desirability. The study was restricted to a particular local government region, hence constraining the generalizability of the findings to broader populations. Cultural sensitivity over sexual health issues may have influenced the thoroughness of responses. The exclusion of non-consenting adolescents may have disregarded essential viewpoints from the most vulnerable populations.

CONCLUSION

This study highlights that teenage pregnancy in Akinyele LGA, Ibadan, is closely associated with cultural and socioeconomic factors. Peer and familial pressures, ingrained cultural taboos around sexual health education, and economic adversity surfaced as prominent factors. The majority of individuals indicated restricted access to open dialogues regarding contraception, highlighting widespread cultural and religious obstacles. Furthermore, inadequate educational achievement and unstable familial structures exacerbated susceptibility to early pregnancy. The results underscore the immediate necessity for multi-sectoral initiatives centered on comprehensive sexuality education, youth empowerment, and poverty reduction. Community involvement, especially with parents and religious leaders, is essential for dismantling detrimental norms. Policy improvements that incorporate reproductive health into elementary school and generate economic possibilities for adolescents are essential. This research provides significant evidence to guide focused measures for decreasing teenage pregnancy and enhancing adolescent reproductive health in Nigeria.

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