Nigerian Journal of Health Promotion
ISSN: 0995-3895
Vol. 10, 2017



# Teenage Pregnancy in Nigeria: Implications for Maternal Health

Chinwe P. Obiekwe
Department of Physiotherapy
University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu

**Abstract**
*Teenage pregnancy is a public health problem that has adverse social, economic and health outcomes in adolescent girls especially in developing countries.The aim of this paper is to highlight the current situation of teenage pregnancy in Nigeria and draw attention to the menace this situation may pose to maternal health. Teenage pregnancy has been attributed to poverty, illiteracy, early girl marriage, violence and other socio-cultural factors. Adverse health outcomes of teenage pregnancy include increased maternal and infant mortality, complications of pregnancy and increased risk of cervical carcinoma. Therefore, addressing and urgently reducing teenage pregnancy in Nigeria will not only help to improve maternal health but also the health of the baby thereby reducing infant mortality.*
**Keywords**: Teenage Pregnancy, Maternal Health, Nigeria, Sexuality

## Introduction

A teenager is a young person between the ages of thirteen and nineteen years of age. The adolescence period is really a transitional stage in development in which the vulnerable young person is becoming sexually active (Salami, Ayegboyin&Adedeji, 2014). This time of life is a critical period in development characterized by physical, intellectual, psychological and social changes. Exposure to new experiences and abuses especially in the area of sexuality, marriage and child-bearing are common during this period.

In 2012, The World Health Organization (WHO), at its sixty-fifth World Health Assembly, reported that as much as 16million girls aged 15 – 19years give birth each year, and 95% of this number are in low and middle income countries. This accounts for 11% of all births worldwide.The same report also highlighted that about one million girls under the age of 15 give birth each year.

Worldwide, teenage pregnancy rates range from143 per 1000 in sub-Saharan Africa to 2.9 per 1000 in South Korea. It is therefore clear that sub-Saharan Africa has the highest rate of teenage pregnancy worldwide (Thobejane, 2015). As at 2008, teenage pregnancy rate in Nigeria was found to be 22.8% although higher local rates have been reported since then. Envuladu, Agbo, Ohize&Zoakah (2014) reported a teenage pregnancy rate of 25.8% in Jos, north-central Nigeria; 22.9% in western Nigeria and 45.4% in a rural community of eastern Nigeria.

Teenage pregnancy is defined as pregnancy in a girl who is yet to attain her twentieth birthday at the end of the pregnancy (Maduforo&Oluwatoyin, 2011; Ekefre, Ekanem&Ekpenyong, 2014). It occurs in different settings and under different circumstances. Teenage girls get pregnant within the context of marriage or other recognized unions; outside marriage; through consexual sex and also through forced sex (Canacho& Chandra-Mouli, 2010).

Teenage pregnancy is a source of concern owing to the fact that it is associated with negative health and socioeconomic consequences (Ezegwui, Ikeakor, Ogbuefi, 2012). There is a greater risk of medical complications associated with teenage pregnancy due to the underdevelopment of the pelvis. This can lead to damage to the reproductive organs and difficulty in childbirths. Other complications include obstructed labour, obstetric fistula and infertility (Babafemi&Adeleke, 2012. In a retrospective study conducted to determine the outcome of teenage pregnancy in the Niger Delta region of Nigeria, Ayuba, and Gani (2012) reviewed a total of 141 deliveries and found that teenagers had significantly more preterm labour and caesarian sections. Reports from Enugu, South-East Nigeria showed that pregnant teenagers had significantly higher rates of malaria in pregnancy, anaemia in pregnanacy and caesarian section delivery than their older counterparts. They were also more likely to present as unbooked cases (Onoh, Ezeonu, Anozie, Esike, Obuna, Egbuji, Agwu, Agboeze&Chukwudi, 2014; Ayuba& Gani, 2012; Ezegwui et al., 2012).

The relationship between teenage pregnancy and poverty is well documented. Socioeconomic disadvantage has been clearly identified as a leading cause of teenage pregnancy but more evidence has emerged pointing to teenage pregnancy as a primary cause of poverty.

Teenage pregnancy is linked to higher levels of poverty and addressing it will contribute to the achievement of the Sustainable Development Goals (SDGs) 1 which centers on ending poverty everywhere. It is estimated that every day 830 women die from pregnancy and childbirth related causes, all of which are preventable. However, women from poor background still face the highest risk of mortality from these causes (WHO, 2016). Further, Goal 3 of the SDGs is on ensuring healthy lives and promoting well-being for all ages. Because pregnancy in teenagers is often associated with poor obstetric outcomes, it poses a threat to the health of mother and child, therefore

preventing and reducing adolescent childbearing is crucial to the health of women, children and adolescents (UN, 2017).Nigeria has a high population of adolescents with high fertility rates. WHO (2011) pointed out that addressing early pregnancies contributes to overall lowering of fertility rates and this is an important factor in improving the overall health and well-being of women and children.With reduction of adolescent pregnancy and childbearing, many girls will be encouraged to remain in education thereby reducing the high school drop-out rate associated with teenage pregnancy. This will definitely be a boost for SDG 4 (ensuring inclusive and quality education for all and improve lifelong learning.

**Causes of Teenage Pregnancy**

The causes of teenage pregnancy have been, and are still being studied all over the world. Some factors which have been implicated include:

**Poverty**. All over the world, teenage pregnancy is associated with poor social and economic conditions and prospects. Even in high income countries, teenage pregnancy rates are higher in the most socioeconomically disadvantaged groups (Sedgh, Finer, Singh &Susheela, 2015). Data from the 2008 Nigeria demographic and health survey suggests that fertility is higher among teenagers from very poor economic backgrounds than their counterpart from richer homes, and poverty was therefore a likely reason for becoming sexually active earlier and for early marriage (Ajala, 2014). Odu and Ayodele (2006) studied the incidence of teenage pregnancy in Ekiti state, south-west Nigeria and found a significant relationship between parental socio-economic status and involvement of teenagers in teenage pregnancy. A similar study from Ogbomosho found that the inability of parents and the family to provide for the financial and material needs of the children was rated highest among the unmet social needs of teenagers before they got pregnant (Salami, Ayegboyin&Adedeji, 2014). Inability of parents to provide for the basic needs of their children, the girl child in this case, creates a push for the girls to engage in illicit sexual behavior in a bid to fend for themselves materially. Since most teenagers do not plan for themselves and for their pregnancies, they ultimately end up living in poor conditions. Furthermore, they may not be receiving any support from their families, community and social services (Thobejane, 2015; Ekefre, Ekanem&Ekpenyong, 2014). This further worsens their plight since most teenagers are usually unemployed and lack the necessary economic resources to care for themselves during and after the pregnancy.

**Early sexual debut**. In low income countries, girls report first sexual experience between ages 15 and 19 and often in the context of marriage or coercion, and with older men (WHO, 2012). 20% of Nigerian women become sexually active by age 15 and 54% by age 18 years (NPC & ICF, 2014). The result of the 2013 demographic and health surveys further showed that teenage orphans and vulnerable children (OVCs) are at high risk of early sexual activity (sexual activity before age 15). This is attributable to the fact that they lack the guidance and supervision of parents and other adults. The same report shows that girls are more likely than boys to engage in sexual activity before age 15.

**Early marriage**. Girl-child marriage is the marriage that occurs before a girl has reached eighteen years of age (UN, 1994). More than 30% of girls in low and middle income countries marry before their eighteenth birthday, and thus naturally begin to have children in their teens. West Africa has the highest rates of early marriage in the world (WHO, 2012). Though there is a gradual increase in age at marriage, early girl marriage is still prevalent especially in the northern parts of Nigeria. 54% of young girls (aged 15 – 24 years) in northern Nigeria, were married by age 15, and 81% were married by age 18 (Erulkar& Bello, 2007).

**Unavailability of health services and poor access to sexuality education.** Many young people not only face barriers to reproductive health information and care, but are also not able to access services even in situations where they have access to accurate information. Reports from South Africa show that a high percentage of teenagers lack access to adequate reproductive health services (Mushwana, Monareng, Richter & Muller 2015). The situation is the same in many countries where effective sexuality education is lacking or inadequate. In developing countries, it is reported that only 24% of young women aged 15 – 24 have comprehensive and correct knowledge of HIV/AIDS. It must be noted that countries with low teenage pregnancy rates (e.g. Switzerland) have long established sexuality education programme among other things (Sedgh, Finer & Singh 2015).

**Illiteracy.** The role of education in preventing teenage pregnancy cannot be overemphasized. Adolescent pregnancies are more likely to occur in uneducated and rural communities (WHO, 2014). In fact, being educated serves as a protection against early pregnancy, and more years of schooling is documented to correlate positively with fewer early pregnancies. Conversely, low education levels are associated with higher risks of maternal mortality (WHO, 2012). In Northern Nigeria, most of the married adolescent girls had much older spouses, and they were also noted to have low levels of education and lacked decision – making power in the marriage (Erulkar& Bello, 2007; Onoh et al, 2014). Further, there is evidence that women who are educated are more likely to have access to safe abortion services while the poor and uneducated tend to patronize unsafe services (Ibrahim, Jeremiah, Abasi&Addah, 2011; Fabamwo, Akinola&Akpan, 2009).

**Cultural/social factors.** In some parts of Nigeria, teenage pregnancy and sexual relationships among teenagers are accepted as norms and are even seen as proof of a girl's fertility, thereby encouraging high rates of sexual activity among teenage girls (Babafemi&Adeleke, 2012). Moreover, certain cultural practices and inhibitions often hinder mothers from fulfilling their responsibility of discussing sex and sexuality issues with their teenage children (Ekefre et al, 2014). The 'Osu' caste system in south-east Nigeria is significantly associated with teenage pregnancy (Uwaezuoke, Uzochukwu, Nwagbo&Onwujekwe, 2014). Girl marriage is often a traditional practice dictated by customary and religious laws and is more prevalent in poorer rural communities (Nwimo&Egwu, 2015). Girls are often married off early by family arrangement, regardless of their choice (Erulkar and Bello, 2007).

**Media and peer group influence**. Many teenagers are exposed to a variety of media, notably home videos, music and the internet. The majority of these media portray being sexually active as glamorous and fashionable. Teenage girls are often under a lot of pressure to conform to what their contemporaries, especially the opposite sex, consider sexy, classy or in-vogue (Ajala, 2014) However, a study from Ogbomosho, south-west Nigeria, showed that 66.1% of pregnant teenagers reported the lack of discouragement from peers not to have boyfriends as a contributing factor in getting pregnant. Peer influence may thus be seen from two dimensions: as a negative influence to get involved in teenage pregnancy; and on the hand as a positive influence not to get involved.

**Rape and sexual assault**. In certain situations, teenage girls are incapable of refusing sexual advances (Ekefre et al, 2014). Sexual abuse of children is a cause of teenage pregnancy in Nigerian girls (Okunola&Ojo, 2012). Often girls are raped and exposed to violence due to insurgency. The violent insurgency in northern Nigeria has turned many teenage girls into mothers when they were forcefully abducted. The famous Chibok Girls saga in North-East Nigeria is a case in point.

**General moral decadence**.Loss of cultural norms and values have been implicated in teenage pregnancy. Also alcohol and substance abuse have been found to play a vital role in encouraging teenage pregnancy (Ekefre et al, 2014). Abstinence in the unmarried remains the best option for preventing teenage pregnancy and this is enhanced by maintaining high moral standards. Where this moral standard becomes lax, teenage pregnancy is likely to increase. Social permissiveness favouring early exposure to casual sexual activity is a contributory Factor in teenage pregnancy (Ayuba&Gani, 2012).

**Implications for Maternal Health**

**Complications of pregnancy**. Globally, complications of pregnancy and childbirth are documented to be the leading causes of mortality among girls between ages 15 – 19 years (WHO, 2014). Mothers in this age group face a 20 – 200% chance of dying in pregnancy than those in 20 – 24 years age group (Ayuba&Gani, 2012). Teenage births account for about 23% of the overall burden of disease due to pregnancy and childbirth (Maduforo&Oluwatoyin, 2011). Approximately 13 million children in the world are born to young women under the age of 20 and more than 90% of them are in the developing countries (Thobejane, 2015). Inadequate prenatal care is documented to be a cause of pregnancy-related complications among teenage mothers owing to the fact that they tend to seek care late in the pregnancy or not at all (Makinson, 1985). Various studies from different parts of the country found that complications of pregnancy were commoner in teenagers when compared with their immediately older pregnant age groups. Anaemia in pregnancy, malaria in pregnancy, pre eclampsia, HIV in pregnancy, preterm labour, caesarean sections, post-partum hemorrhage and poor fetal outcomes are the most common complications (Onoh et al 2014; Uwaezuoke, Uzochukwu, Nwagbo&Onwujekwe 2004; Ayuba&Gani, 2012). Post-natal depression and poor mental health have also been documented among pregnant teenagers (Babafemi&Adeleke, 2014).

**Increased risks of sexually transmitted diseases and cervical carcinoma**. Teenagers becoming pregnant obviously shows that they are sexually active. It is documented that HIV infection is common among teenage mothers. The incidence of cervical carcinoma is directly linked to the age at first intercourse. This deadly disease is unfortunately increasing in incidence and also presenting at younger ages (Ayuba&Gani, 2012).

**Post-abortion infections and other co-morbidities.** Except in situations of marriage, pregnancy among adolescent girls is often unwanted and unplanned, and as such they often resort to unsafe abortions. Unsafe abortion is an induced abortion to terminate an unwanted pregnancy and which is performed outside of formal healthcare system by unskilled providers under unsanitary conditions (Ibrahim et al, 2011; Fawole, Aboyeji&Akande, 2006). Reports from Jos, Nigeria show that 72.7% of all teenagers who had an abortion had it at home or in a chemist shop. Post-abortion complications occurred in 81.8% of cases (Envuladu et al, 2014). 97% of all unsafe abortions take place in developing countries and because of the clandestine nature of unsafe abortions, much of it goes unreported and therefore undocumented (Haddad and Nour, 2009), except where serious complications that warrant hospital admissions arise. Globally, about 5million women require hospital admissions for abortion-related complications annually. Unsafe abortion is one of the leading causes of maternal mortality worldwide (Ibrahim et

al, 2012). Data from a 2012 estimate observed that an estimated 1.25 million cases of induced abortion occurred in Nigeria. In a four-year review of complicated unsafe abortions in the Niger Delta region, Ibrahim et al (2011) reported that teenagers comprise a significant number (31.8%) of all women presenting with complications of unsafe abortions. The same study documented that the highest complications were genital sepsis (88.9%), retained products of conception (82.5%) and pelvic abscess (22.2%). Other complications were septicaemia, perforated uterus, haemorrhagic shock, gangrenous uterus, acute renal failure, perforated intestine, bladder injury and tetanus. A similar study by Fawole and Aboyeji (2002) at Ilorin, south-west Nigeria, found complications comprising of sepsis (92.7%), abscess (64.9%), visceral injuries (28.2%) and haemoperitoneum (25.9%).

**Future infertility**. This is a serious sequel of teenage pregnancy and is mainly due to unsafe abortions and the attendant infections (Ibrahim, Jeremiah, Abasi &Addah 2011). Birth trauma and complications also impact negatively on the future fertility of the girl.

**Increased maternal and child mortality**. It is established that complications of pregnancy and abortion increase the risk of death in pregnant teenagers (Onoh et al, 2014). This risk of mortality is higher for girls under 15 years of age than for those in their twenties, showing that teenage pregnancy can lead to devastating health consequences for the girls (UNFPA, 2014). Teenage pregnancy is also dangerous for the child. Teenage girls have higher chances of preterm delivery, low birth weight babies and asphyxia than their older counterparts. These increase the risk of perinatal and infant mortality and other future health challenges for the baby (WHO, 2012; Camachco& Chandra-Mouli, 2010). In a study to determine the incidence of teenage pregnancy and compare obstetric and neonatal complications of teenage mothers and their adult mothers, Watcharaseranee, Pinchantra&Piyaman (2006) reported that teenage mothers had inadequate antenatal care and low birth weight babies than their older counterparts. Another prospective study comparing the outcome of sick babies born to teenage mothers with those born to older mothers in Thailand found a significantly high mortality among babies born to teenage mothers than those born to their older counterparts. The same study found that babies of teenage mothers were significantly more preterm and had higher blood pressure. Gastroschicis was found only in babies of teenage mothers. Further, more cases born to teenage mothers had delayed speech than those born to older mothers. In a similar study from Nairobi Kenya, Taffa (2003) reported that babies born to teenage mothers died more frequently and this was probably due to the poor socioeconomic status of the teenage mothers. In the same vein, LeGrand& Macke (1993) conducted a longitudinal study in Mali and Burkina Faso and reported earlier weaning of babies born to teenage mothers and higher mortality especially during the second year of life. In Nigeria, Ayuba&Gani (2012) reported a perinatal mortality rate of 133 per 1000 in the Niger-Delta region.

## Conclusions

A review of the literature on teenage pregnancy shows that it is a persisting public health problem and developing countries, including Nigeria, are more affected that the more advanced countries. A significant proportion of teenage pregnancies among Nigerian girls occur in conditions of early marriage. Poor socioeconomic status of the teenage mothers is implicated in the poor maternal and child health indices prevalent in teenage pregnancy. Other contributing factors include peer influence, media and cultural factors. Several economic, social and health sequelae accompany teenage pregnancy and create a heavy burden on the economy and the life of Nigerian women and children.

Nigeria had an adolescent population of 30 million and a teenage pregnancy rate of 22.9% as at 2008. It is clear that teenage pregnancy is a public health issue that is capable of slowing down the achievement of the nation's hope of improving overall maternal and child health indices. Therefore prevention of teenage pregnancy is an effective intervention towards the realization of these noble goals.

## Recommendations

In the light of the foregoing, the following measures are recommended:

1) Reproductive health services should be made adolescent –friendly. Health facilities that offer reproductive health services should provide separate services for young people (e.g adolescent or teen clinics) in other to boost their confidence in the system and to safeguard their anonymity. National and international efforts aimed at addressing maternal health challenges should bear this population of Nigerians in mind. Moreso, teenagers should be involved as much as possible in developing and implementing programs that address their reproductive health.
2) Sexual and reproductive health information, as well as other adolescent health problems should be tackled as a preventive public health intervention. This can be achieved through schools, Churches and other faith-based organizations, women groups and other social groups. These should be carried along and encouraged to become collaborators in the National Adolescent Health Strategy. Further, young girls should be empowered through targeted education on their rights as enshrined in relevant laws, and this should include information on how and where to seek help when they feel that these rights are being

infringed on. Due to traditional family structures, many young girls may feel afraid to refuse being given away in marriage against their wish, or to report unwanted sexual advances. So providing information on how, when and where to seek help may prove invaluable in helping teenage girls avoid unwanted pregnancies. Moreover, it is important to engage boys and men as collaborators in reducing teenage pregnancy. It should not be viewed as a girls' or women's affair only.

3) There is an urgent need to address the cultural and social issues that promote teenage pregnancy. This includes enforcing legislations on early marriage, rape and sexual violence. The Media should rise up to this challenge and raise public awareness on this social and public health challenge.
4) There should be a more coordinated research effort to raise meaningful data on teenage pregnancy; availability, accessibility and utilization of maternal health services especially in rural populations.
5) There should be a program of social support and re-integration for teenage mothers in other to forestall a second pregnancy. Affected girls should be assisted to pull through the pregnancy, and then supported to get back into a normal life by, for example, going back to school or skills-training or by getting a job to support herself and live a meaningful life. Becoming pregnant as a teenager should not become the end of a young girl's future.

**References**

Ajala, A.O. (2014). Factors associated with teenage pregnancy and fertility in Nigeria. *Journal of Economics and Sustainable development.5*(2), 62 – 70.

Ayuba, I.I &Gani O. (2012).Outcome of teenage pregnancy in the Niger Delta of Nigeria.*Ethiopian journal of Health Sciences.22*(1), 45 – 60. Available at www.ncbi.nlm.nih.gov/pubmed/22984331.

Ayuba, I.I &Gani O. (2012).Socio-demographic determinants of Teenage Pregnancy in the Niger Delta of Nigeria.*Open Journal of Obstetrics and Gynecology*. 2: 239 – 243. Available at http://www.SciRP.org/journal/ojog/.

Babafemi, AA &Adeleke, AJ (2012).Health and Social Problems of Teenage Pregnancy and Future Childbearing in AmassomaCommunit, Bayelsa State, Nigeria.*Research Journal of Medical Sciences.6*(5), 251 – 260.

Bankole, A, Adewole, F. F., Hussain, R, Awolude, O, Singh, S &Akinyemi, J (2015).The Incidence of Abortion in Nigeria.*International Perspectives on sexual and Reproductive Health.41*(4), 170 – 181. Available at https://guttmacher.org/about/journal/ipsrh.

Camacho, A.V & Chandra-Mouli, V (2010). Adolescent Pregnancy: A global perspective. *Training course in Sexual & Reproductive Health Research.*WHO. Geneva.

Chotigeat, U &Sawasdiworn S (2011).Comparison of Outcomes of Sick Babies Born to Teenage Mothers to those Born to Adult Mothers.*Journal of Medical Association of Thailand.94 (suppl 3), S27 – 34.*

Ekefre, E.N, Ekanem, S.A &Ekpenyong, E.O (2014). Teenage Pregnancy and Education in Nigeria: A philosociological Management Strategy. *Journal of Educational and Social Research.4*(3), 41 – 47.

Envuladu, E.A, Agbo, H.A, Ohize, V.A, Zoakah, A.I (2014). Determinants and Outcome of Teenage Pregnancy in a Rural Community in Jos, Plateau State, Nigeria.*Sub-Saharan African Journal of Medicine (Serial online).* Available at http://www.ssajm.org/text.asp?2014/1/1/48/

Erulkar, A & Bello, M (2007).The Experience of Married Adolescent Girls in Northern Nigeria. The Populations Council Inc.Available at www.ohchr.org

Ezegwui, H.U, Ikeakor, L.C&Ogbuefi, F (2012).Obstetric Outcome of Teenage Pregnancies at a Tertiary Hospital in Enugu, Nigeria.*Nigerian Journal of Clinical Practice.15*(2),147 – 150.

Fabamwo,A.O, Akinola, O.I, Akpan, A.E (2009). Correlates of abortion related maternal mortality at the Lagos state university Teaching Hospital. Ikeja.*African Journal of Reproductive Health.13(2), 139 – 46.*

Fawole, A.A &Aboyeji, A.P (2002).Complications from unsafe Abortions: Presentations at Ilorin, Nigeria. *Nigeria Journal of Medicine.11*(2), 77 – 80.

Goncalves, H, Souza,AD, Tavares, PA, Cruz, SH &Behague, DP (2011). Contraceptive Medicalization, Fear of Infertility and Teenage Pregnancy in Brazil. *Culture, Health & Sexuality.13* (2), 201 – 215.

Grimes, D.A, Benson, J, Singh, S, Romero, M. Ganatra, B, Okonofua, F.E, Shah, I.H (2006). Unsafe Abortion: The Preventable Pandemic. WHO, Department of Reproductive Health.

Haddad, L.B &Nour, N.M (2009). Unsafe Abortion: Unnecessary Maternal Mortality. *Reviews in Obstetrics and Gynecology.2*(2), 122 – 126.

Ibeh, C &Ikechebelu, J.I (2002). Teenage Pregnancy: Knowledge and Attitude of Adolescents in South East Nigeria. *International Journal of Medicine and Health Development.*7(2),104 – 107.

Ibrahim, I.A, Jeremiah, I, Abasi, I, Addah, A.O (2011). Pattern of Complicated Unsafe Abortion in Niger Delta University Teaching Hospital Okolobiri, Nigeria: A four year review. *The Nigeria Health Journal.11*(4), 112 – 116.

LeGrand, T.K. &Mbacke, C.S (1993).Teenage Pregnanacy and Child Health in the Urban Sahel.*Studies in Family Planning. 24*(3),137 - 49.

Maduforo, A.N. &Oluwatoyin, O (2011).Prevalence of Adolescent Pregnancy in Ganye LGA, Adamawa State, Nigeria.JORIND.*9* (2).Available at www.ajol.info/journal/jorind.

Makinson, C (1985). The Health Consequences of Teenage Fertility.*Family Planning Perspectives. 17*(3), 132 – 9

Mushwana L, Monareng, L, Solina, Richter & Helene, Muller (2015). Factors Influencing the Adolescent Pregnancy Rate in the Greater Giyani Municipality, Limpopo Province South Africa. *International Journal of Africa Nursing Sciences.*Available at *www.ciencedirect.com/science/article/pii/52214139115000025*.

National population commission(NPC) & ICF International (2014).*Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria & Rockville, Maryland USA: NPC and ICF International.

Nwimo, I.O &Egwu, S.O (2015). Girl Child Marriage: implications for Community Intervention Programmes. *Journal of Law, Policy and Globalization. 37: 141 - 149*

Odu,B.K&Ayodele, C.J (2006). The Incidence of Teenage Pregnancy in Ekiti State, Nigeria.*Nigerian Journal of Guidance and Counselling*.*11*(1), 25 – 33.

Onoh, R.C, Ezeonu, P.O, Anozie, B.O, Esike, C.O.U, Obuna, J.A,Egbuji, C, Agwu, U.M, Agboeze, J&Chukwudi, I.P (2014). Outcome of Teenage Pregnanacy at a Tertiary Hospital in Abakaliki South Eat Nigeria. *Journal of Basic and Clinical Reproductive Services. 3*(1), 22 – 26.

Okunola, R.A &Ojo (2012). The causal Relationship between Child Abuse and Teenage Pregnancy: Perspective of the Crawford University Students in Nigeria. *International Journal of Prevention and Treatment. 1*(4), 67 – 77.

Salami, KK, Ayegboyin, M, &Adedeji,IA(2014). Unmet Social Needs and Teenage Pregnancy in Ogbomosho, South/West Nigeria.*African Health Sciences.14*(4), 956 – 966.

Sedgh, G, Finer,L.B, Singh, S (2015). Adolescent Pregnancy, Birth and Abortion Rates Across Countries: Levels and Recent Trends. *Journal of Adolescent Health. 56*(2), 223 – 230.

Taffa, N.(2003). A comparison of Pregnancy and Child Health Outcomes Between Teenage and Adult Mothers in the Slums of Nairobi, Kenya. *International Journal of Adolescent Medicine and Health.15* (4), 321 – 9.

Thobejane, T.D.(2015). Factors contributing to teenage pregnancy in South Africa: The case of Matjitjileng village. Journal of Sociology and social Anthropology. 6(2): 273 – 277.

UNFPA (2014). Adolescent pregnancy.Available at www.unfpa.org/adolescent-pregnancy.

Uwaezuoke, AIO, Uzochukwu,BSC, Nwagbo,DFE, Onwujekwe,EO, (2014). Determinants of Teen Pregnancy in Rural Communities of Abia State, South East Nigeria.*Journal of College of Medicine.* 9(1):28 – 33).

Watcharaseranee, N, Pinchantra, P &Piyaman, S (2006).The Incidence and Complications of Teenage Pregnancy at Chonburi Hospital.*Journal of Medical Association of Thailand. 89*(suppl 4),S118 - 23.

WHO (2011).Making Pregnancy Safer. http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.

WHO (2014).*Adolescent Pregnancy*. Available at www.whi.int/mediiacentre/factsheets/fs364/en

WHO (2016). *Health topics: Maternal Health.* Available at www.who.int/topics/maternal_health /en/

WHO, Human Reproductive Programme (2016).*Sexual and Reproductive Health*.Available at www.who.int/reproductivehealth/news/maternal-death/en.