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Original Research Article

Prevalence and factors associated with teenage pregnancy in Nepal

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ABSTRACT

Background: Every year, approximately 16 million adolescents give birth globally, accounting for 11% of all births worldwide. 95% of these births take place in low- and middle-income nations. The objective of this study was to assess the prevalence and contributing factors related to teenage pregnancy in Nepal.
Methods: Standardized data was sourced from the NDHS 2016. This cross-sectional survey was representative of the national population, utilizing a multistage cluster sampling method. Data collection was carried out through three sets of structured questionnaires. Authorization for data usage has been secured from the relevant agency. Statistical analyses were performed using STATA.
Results: NDHS 2016 reported a teenage pregnancy prevalence was 16.7%. Among those aged 15 to 19, 61% were married. The incidence of teenage pregnancy was notably low among Brahmin/Chhetri (11.5%), highest among Muslims (22.7%), and lowest among Buddhists (12.8%). The middle wealth category exhibited the highest prevalence. Additionally, teenage pregnancy was more prevalent in rural areas, particularly in Terai. A significant association was found between the age of respondents and teenage pregnancy and the employment status of respondents ($p<0.05$). However, the educational attainment of respondents did not demonstrate any significant association with teenage pregnancy.
Conclusions: The prevalence was highest among the Madhesi community followed by Muslims. The age of the respondents or marriage before the age of 19, economic status of the respondents, rural place of residence, and occupation of the respondents were significantly associated with teenage pregnancy in Nepal.

Keywords: Nepal, Pregnancy, Teenage

INTRODUCTION

The adolescent stage encompasses individuals aged 10 to 19 years.[1] Adolescent pregnancy remains a multifaceted and difficult challenge for families, healthcare professionals, educators, communities, governments, and the adolescents involved.[2] One significant contributor to the swift increase in global population is the occurrence of adolescent childbearing.[3] The United Nations also notes that early childbearing poses significant health risks for both the mother and the child.[4]

The capacity of youth to contribute to development is acknowledged both in Nepal and globally. Nevertheless, circumstances such as early pregnancies among adolescent girls can lead to irreversible effects on youth development. This situation infringes upon the rights of girls, resulting in life-threatening implications for their sexual and reproductive health, and imposes significant developmental burdens on communities, especially by sustaining the cycle of poverty.[5] The Convention on the Rights of the Child (CRC) and the International Conference on Population and Development (ICPD) both

pledge to eradicate detrimental traditional practices, including child marriage and adolescent pregnancy. In Nepal, adolescents represent approximately one-quarter of the overall population, with national estimates indicating that the rate of early pregnancy among individuals aged 15 to 19 is 17%.[6] The adolescent demographic is at a greater risk compared to individuals aged 20 to 24 regarding sexual and reproductive health issues, which include early marriage, hazardous sexual practices, unintended pregnancies, sexually transmitted infections, and HIV/AIDS.[7] Recent research indicates that there has been a notable increase in adolescents' understanding and awareness of sexual and reproductive health issues, alongside an enhancement in the accessibility of health services for all age demographics in Nepal. Nevertheless, these advancements in knowledge and service availability have not translated into the anticipated changes in adolescent behavior. For example, while there is greater awareness of contraceptives, this has not corresponded with a rise in their usage.[8] To effectively reduce adolescent pregnancies, it is essential to shift the focus from placing blame on young women to addressing the societal conditions that render marriage and motherhood their sole alternatives. A comprehensive approach requires us to examine the root causes of adolescent pregnancy, which encompass gender inequality, poverty, sexual violence, societal pressures, detrimental attitudes and stereotypes regarding women and girls, as well as the prevalence of child marriage.[9] Early marriage serves as a significant factor contributing to early pregnancy. This practice, often referred to as child marriage, is characterized by unions formed before the age of 18. Such marriages occur before the girl reaches a level of physical, physiological, and psychological maturity necessary to undertake the responsibilities associated with marriage and motherhood.[10] In Nepal, the majority of early pregnancies occur within the context of marital relationships.[11] The traditional characteristics of the society are noteworthy. Although legislation mandates that the legal marriage age is set at 18 years for both males and females with guardian consent, it is established at 20 years in the absence of such consent.[12] Early marriage remains prevalent among numerous ethnic groups. In Nepal, adolescents make up approximately 24 percent of the population.[13] According to the Nepal Demographic Health Survey (NDHS) 2006, approximately 20 percent of late adolescent girls aged 15 to 19 are either mothers or pregnant with their first child. This statistic is significantly higher than that of several SAARC nations, including Pakistan and India, both at 16 percent. This indicates that the reproductive health situation for adolescents in Nepal is concerning, particularly in rural areas where the lack of education, information, and awareness programs exacerbates the issue. Adolescent fertility poses a significant social and health challenge, as teenage mothers are at a greater risk of experiencing complications during pregnancy and childbirth, which can impact the health and survival of both the mother and the child. Furthermore, early marriage, or child marriage, is prevalent in many rural regions of Nepal. The NDHS 2006 reveals that nearly 50 percent of girls are married by the age of 15, and 40 percent have their first child between the ages of 15 and 19, an age at which many women are not adequately prepared for motherhood, either physically or mentally. Additionally, the contraceptive prevalence rate remains low, standing at only 29 percent.

METHODS

Source of data

NDHS 2016 data were used for the study. NDHS was a cross-sectional study, and it provides nationally representative information. NDHS takes place every five years. NDHS 2016 collected information about teenage pregnancy and teenage childbearing in Nepal. The survey was conducted by the New ERA in close coordination with the Ministry of Health Nepal from June 2016-January 2027. United States Agency for International Development (USAID) provided financial support. Technical support was provided by ICF International through the Measure DHS program of USAID [Ministry of Health and Population (MOHP) (Nepal) et al, 2016]. Data were freely available on the Measure DHS website www.measuredhs.com.

NDHS 2016 collected information from women of 15-49 years using women's questionnaires. Data on teenage pregnancy were obtained from a woman of 15-19 years from the household selected for women's interview. women's questionnaire was asked in every household [Ministry of Health (MOH) (Nepal) et al, 2016]. To make data use easy, Measure DHS recoded data into different data sets. For this study, an individual data set of NDHS 2016 was used.

Sampling

The 2016 NDHS sample was stratified and was selected in two stages in rural areas and in three stages in urban areas. In rural areas, wards were selected as primary sampling units (PSUs), and households were selected from the sample PSUs. In urban areas, wards were selected as the PSUs, one EA was selected from each PSU, and then households were selected from the sample EAs. Each federal state was stratified into urban and rural areas yielding 14 sampling strata. Samples of wards were selected independently in each stratum. Implicit stratification and proportional allocation were achieved at each of the lower administrative levels by sorting the sampling frame within each sampling stratum before sample selection, according to administrative units in different levels, and by using a probability-proportional-to-size selection at the first stage of sampling. Thus, in the first stage, 383 wards were selected with a probability proportional to the ward size and with independent selection in each sampling stratum within the sample allocation. The ward size is the number of residential

households residing in the ward census used in the 2011 NPHC. Due to the large size of the urban wards, in the second stage of sample selection for urban areas, one EA was randomly selected from each of the sample wards. A household listing operation was carried out in all of the selected sampling clusters (rural wards or urban EAs), and the resulting lists of households served as the sampling frame for the selection of households in the next stage.

All women aged 15-49 who were either permanent residents of the selected households or visitors who stayed in the households the night before the survey were eligible to be interviewed. In half of the households (every second household) selected, all men aged 15-49 who were either residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed. The survey involved the collection of biomarker information from a subsample of the households.

The fieldwork for the pretest was carried out in three locations focusing on the three language groups of Nepal (Maithili, Bhojpuri, and Nepali).

To answer the research questions, a subsample was drawn from the women of 15-19 years who were selected and interviewed for pregnancy and childbearing. The number of women included in the analysis was determined considering the pregnancy during the period of the survey or have children of the teenagers during the interview.

Statistical analysis

STATA 12 was used to analyze the data (StataCorp, 2011). Univariate, bivariate, and multivariate analyses were carried out as needed. Simple descriptive information was given for the socio-demographic status of women and the prevalence of teenage pregnancy. A chi-square test was carried out to explore the association of teenage pregnancy and socioeconomic factors, possible confounders, and outcomes. Percentage, 95% confidence interval (CI), and p value (<0.05 as significant) were presented to describe the relationships of the outcome and exposure variables with socio-demographic variables i.e. background variables. Multiple logistic regressions were carried out to explore the relationships between the outcomes. Before running regression analysis, the data set was declared as a 'survey data set' because the data were taken from the survey which had a complex design based on two stages stratified sampling procedure. Jackknife repeated replication method was used in the logistic models to estimate the standard error and confidence intervals.

Ethical approval

As the study was based on the secondary analysis of the existing data, ethical issues about the data collection did not require a new ethics clearance process for this study. All ethical requirements and guidelines necessary to follow while conducting research in Nepal were maintained by the implementation agency of NDHS 2016. The data set was available to download. To have access to the register, the authors registered themselves through www.measuredhs.com and then requested access to the data set of Nepal. After getting permission to use it, the data was downloaded and used in this study.

RESULTS

Background characteristics

Out of 2598 respondents of all the age groups of 15-19 years, 16 years (21.93%) had the highest number of teenage women followed by 18 and 19 years (20% and 19.99% respectively). 18.43% was from the age of 15 years. More than 70% were not union within this age group. 27% were married and below 1% were separated, divorced, and widowed. 35% were from Janjati followed by Brahmin/Chhetri (26%) and Madhesi (17.25%). Most respondents were from the Hindu religion.

The wealth index of the respondents was similar. Around 20% were poor, 21% middle, and 22% rich. The highest numbers of women were from the Terai region followed by the hill and mountain regions. More than 60% of women resided in the urban region. More than 80% of respondents had secondary and higher education and around 6% had no education. Around 69% husband of the respondents had secondary and higher secondary education followed by primary and below 10% had no education. Around half of the respondents had no specific occupation. Agriculture was the occupation of four in ten women and one in ten was paid job. Regarding the husband's occupation, 46% had manual work followed by paid jobs and agriculture.

Prevalence of teenage pregnancy by background characteristics

Out of the total respondents to the survey, 16.7% got pregnant within 15-19 years. The majority of the pregnancy were from the age of 19 years followed by 18 and 17 years. 1.5% of women had pregnant age the age of 15 years. Among the total pregnant women of 15-19 years, 61% were married and 52% were divorced. Teenage pregnancy was found among Madhesi followed by Muslims and Dalits. Only 11.5% of teenage pregnancy was found among Brahmin/Chhetri. Teenage pregnancy was found highest in the Muslim religion (22.7%) and lowest in the Buddhist (12.8%).

According to the wealth index of the respondents, a high prevalence of teenage pregnancy was found among the middle index followed by the poorest and poor. Only 5.9% of teenage pregnancies were found among the richest wealth index. The prevalence of teenage pregnancy was found higher among rural than among the residents. Terai region is more vulnerable to teenage

pregnancy. The prevalence of teenage pregnancy is comparatively low in the hilly region of Nepal. Occupation plays an important role in teenage pregnancy.

Our analysis showed that those who had no work had a higher prevalence of teenage pregnancy followed by agriculture and manual work. Those who had paid jobs had less than 5% prevalence of teenage pregnancy. Those respondents whose husband's occupation was agriculture had a higher prevalence of teenage pregnancy. The respondents who had no education had the highest prevalence of teenage pregnancy than primary and secondary or higher education. The respondents whose husband's education was higher secondary or higher had a low prevalence of teenage pregnancy.

Factors associated with teenage pregnancy

Logistic regression bi-variant analysis showed that the age of the respondent is significantly association with teenage pregnancy ($p<0.05$). Table 3 reflected that the caste and religion of the respondents had no association with teenage pregnancy in Nepal. The wealth index of the respondents had a significant association with teenage pregnancy. The place of residents as per the urban and rural categories had significantly associated with teenage pregnancy. Those who live in the rural had a higher chance of teenage pregnancy. However ecological zone of the respondents had no association with teenage pregnancy. The paid job of the respondents was strongly associated with teenage pregnancy ($p<0.05$). The educational level of respondents had no association with teenage pregnancy.

Table 1: Background characteristics of respondents.

Current age (in years)	Number	Percentage
15	479	18.43
16	570	21.93
17	510	19.63
18	520	20.01
19	520	19.99
Total	2598	100.00
Current marital status		
Never in union	1885	72.54
Married	704	27.11
Widowed	1	0.05
Divorced	3	0.11
Separated	5	0.20
Total	2598	100.00
Caste		
Brahmin/Chhetri	675	25.99
Madhesi	448	17.25
Dalit	387	14.88
Janajati	910	35.04
Muslim	169	6.51
Others	9	0.33
Total	2598	100.00
Religion		
Hindu	2184	84.05
Buddhist	139	5.33
Muslim	170	6.53
Others	106	4.09
Total	2598	100.00
Wealth index		
Poorest	504	19.39
Poorer	515	19.80
Middle	545	20.96
Richer	584	22.46
Richest	452	17.38
Total	2598	100.00
Place of residence		

Continued.

Current age (in years)	Number	Percentage
Urban	1603	61.68
Rural	996	38.32
Total	2598	100.00
Ecological zone		
Mountain	169	6.52
Hill	1095	42.15
Terai	1334	51.33
Total	2598	100.00
Husband's occupation		
No work	33	5
Paid job	223	31.6
Agriculture	116	16.5
Manual	322	45.8
Don't know	11	1.5
Total	704	100.1
Occupation of respondent		
No work	1216	46.80
Paid job	157	6.05
Agriculture	1100	42.32
Manual	114	4.38
Don't know	11	0.44
Total	2598	100.00
Education status of respondent		
No education	159	6.10
Primary	347	13.34
Secondary or higher	2093	80.55
Total	2598	100.00
Husband's education		
No education	69	9.73
Primary	154	21.82
Secondary or higher	482	68.45
Total	704	100.00

Table 2: Prevalence of teenage pregnancy by background characteristics.

	Teenage pregnancy among 15-19 years				
	No		Yes		Total
Current age (in years)	**No**	**Percentage**	**No**	**Percentage**	
15	472	98.5	7	1.5	479
16	545	95.6	25	4.4	570
17	440	86.2	70	13.8	510
18	374	71.9	146	28.1	520
19	335	64.5	184	35.5	520
Total	2165	83.3	433	16.7	2598
Current marital status					
Never in union	1,885	100.0	0	0.0	1,885
Married	274	39.0	430	61.0	704
Widowed	0	0.0	1	100.0	1
Divorced	1	47.8	1	52.2	3
Separated	4	84.9	1	15.1	5
Total	2,165	83.3	433	16.7	2,598
Caste					
Brahmin/Chhetri	598	88.5	77	11.5	675
Madhesi	340	75.9	108	24.1	448

Continued.

Teenage pregnancy among 15-19 years					
Dalit	304	78.7	82	21.3	387
Janajati	782	85.9	129	14.1	910
Muslim	132	78.1	37	21.9	169
Others	9	100.0	0	0.0	9
Total	2165	83.3	433	16.7	2598
Religion					
Hindu	1819	83.3	364	16.7	2184
Buddhist	121	87.2	18	12.8	139
Muslim	131	77.3	38	22.7	170
Others	93	88.0	13	12.0	106
Total	2165	83.3	433	16.7	2598
Wealth index					
Poorest	406	80.5	98	19.5	504
Poorer	413	80.2	102	19.8	515
Middle	426	78.2	119	21.8	545
Richer	496	84.9	88	15.1	584
Richest	425	94.1	27	5.9	452
Total	2165	83.3	433	16.7	2598
Place of residence					
Urban	1391	86.8	211	13.2	1603
Rural	773	77.7	222	22.3	996
Total	2165	83.3	433	16.7	2598
Ecological zone					
Mountain	141	83.1	29	16.9	169
Hill	933	85.2	162	14.8	1095
Terai	1091	81.8	243	18.2	1334
Total	2165	83.3	433	16.7	2598
Husband's occupation					
No work	15	47.0	17	53.0	33
Paid job	82	36.9	141	63.1	223
Agriculture	39	33.5	77	66.5	116
Manual	134	41.8	188	58.2	322
Don't know	4	33.0	7	67.0	11
Total	274	39.0	430	61.0	704
Occupation of the respondent					
No work	992	81.5	225	18.5	1216
Paid job	150	95.1	8	4.9	157
Agriculture	912	82.9	188	17.1	1100
Manual	100	88.2	13	11.8	114
Don't know	11	100.0	0	0.0	11
Total	2165	83.3	433	16.7	2598
Education status of the respondents					
No education	107	67.4	52	32.6	159
Primary	244	70.3	103	29.7	347
Secondary or higher	1815	86.7	279	13.3	2093
Total	2165	83.3	433	16.7	2598
Husband's education					
No education	22	32.0	47	68.0	69
Primary	56	36.5	98	63.5	154
Secondary or higher	196	40.8	286	59.2	482
Total	274	39.0	430	61.0	704

Table 3: Factors associated with teenage pregnancy.

Risk of teenage pregnancy (result of logistic regression)				
Background characteristics	Odds ratio	P value	95% CI	
Age of respondents (years)				
15	1.0			
16	2.5	0.021	1.15	5.44
17	9.4	0	4.59	19.19
18	26.7	0	13.33	53.56
19	40.3	0	20.12	80.59
Caste				
Brahmin/Chhetri	1			
Madhesi	2.7	0	1.70	4.27
Dalit	2.3	0	1.59	3.33
Janajati	1.3	0.149	0.92	1.78
Religion				
Hindu	1.0			
Buddhist	0.7	0.271	0.35	1.34
Others	1.0	0.975	0.55	1.79
Wealth index				
Poorest	1.0			
Poorer	0.9	0.413	0.62	1.22
Middle	0.7	0.068	0.49	1.03
Richer	0.6	0.006	0.38	0.85
Richest	0.3	0	0.15	0.45
Place of residence				
Urban	1.0			
Rural	1.3	0.074	0.98	1.61
Ecological zone				
Mountain	1.0			
Hill	1.2	0.411	0.76	1.97
Terai	0.9	0.666	0.52	1.52
Occupation of the respondent				
Did not work	1.0			
Paid job	0.3	0.002	0.17	0.67
Agriculture	0.8	0.1	0.62	1.04
Manual	0.5	0.052	0.29	1.01
Educational level of the respondent				
No education	1.0			
Primary	0.9	0.735	0.55	1.53
Secondary or higher	0.4	0	0.26	0.69

DISCUSSION

One significant contributor to the swift increase in global population is adolescent childbearing. Annually, approximately 14 million girls are wed before reaching the age of 18. There is an unprecedented acknowledgment that child marriage violates their rights and represents a considerable obstacle to development.[14] In recent decades, adolescent pregnancy has emerged as a significant health concern in numerous countries, both developed and developing. However, this issue is not a recent occurrence. In many regions of the world, such as South Asia, the Middle East, and North Africa, the age of marriage has historically been low within kinship-based societies and economies. In these contexts, most girls married shortly after reaching menarche, resulting in high fertility rates and a considerable number of children born to adolescent mothers, which was not perceived as problematic. Conversely, in Europe during the 18th and 19th centuries, the age of marriage was relatively high, and societal norms strongly discouraged premarital sexual activity; when conception did occur, it typically led to early marriage. As economies advanced and educational opportunities for young people expanded, parental authority began to wane, leading to a decline in social control exerted by families. Over the past century, many Western societies have witnessed a significant rise in sexual activity among adolescents and an increase in

pregnancies, particularly following the second world war. During the 1960s and 1970s, both the general public and health authorities began to regard the rising incidence of adolescent pregnancies as a pressing issue. Similar trends have been observed in various developing nations, including sub-Saharan Africa and Latin America, where there has been a gradual transition from extended family structures to nuclear families. This shift has diminished the role of extended family members in educating and serving as role models for young people regarding sexual behavior.[15] Two significant occurrences during adolescence have had a profound impact on these developments. The first is the shifting age of menarche, which exhibits considerable variation across different populations, with a median age of approximately 12.5 years in modern western nations compared to over 15 years in underprivileged developing countries (Becker, 1993). Historical records from the United States and various European nations indicate a distinct secular trend, revealing that the age at menarche has decreased by approximately 2 to 3 months per decade since the 19th century, culminating in an overall reduction of about three years.[16] In Nepal, the age at which menarche occurs frequently shows an inverse relationship with socioeconomic status. Notable disparities are observed between urban and rural demographics, as well as between high-income and low-income groups.

The second significant factor impacting adolescence is education. Schooling provides individuals with various social and economic advantages, and a considerable portion of adolescence is dedicated to academic pursuits for both boys and girls. This extended period of education has resulted in adolescents becoming more independent from their parents and families, while also delaying the age at which they marry, consequently postponing the onset of socially accepted sexual relationships.[17]

In 2008, the United States had the highest teenage birth rate among developed nations, accompanied by a significant teenage rate. By 2010, the birth rate for this demographic in the U.S. had declined to 34.3 births per 1,000 women aged 15 to 19. In South Asian countries, reported teenage pregnancy rates are 35% in Bangladesh, 21% in Nepal, and 21% in India. Recent statistics indicate that India has a notably high rate of teenage pregnancy, with 62 pregnancies per 1,000 women. Conversely, Indonesia and Malaysia have experienced a sharp decline in early marriage and pregnancy rates. In contrast, industrialized Asian countries such as South Korea and Singapore exhibit some of the lowest teenage birth rates globally.[18]

Numerous factors contribute to the rise of teenage pregnancy, and these factors can differ across various populations. In developed nations, teenage pregnancies typically take place outside of marriage and are often associated with a social stigma in many communities and cultures. Conversely, in certain developing countries and cultures, teenage pregnancies frequently occur within the context of marriage and are generally not accompanied by social stigma.[19]

In Nepal, adolescents make up approximately 23 percent of the population (CBS, 2002). The Nepal Demographic Health Survey (NDHS) 2006 indicates that around 20 percent of late adolescent girls, aged 15 to 19, either become mothers or are pregnant with their first child. This statistic is significantly higher than that of several SAARC nations, including Pakistan and India, both at 16 percent. Consequently, the reproductive health situation for adolescents in Nepal is concerning, particularly in rural regions where educational resources, information, and awareness programs are lacking. The issue of adolescent fertility poses significant social and health challenges. Teenage mothers face an increased likelihood of experiencing complications during pregnancy and childbirth, which can adversely affect the health and survival of both the mother and the child. Furthermore, early or child marriage is prevalent in many rural areas of Nepal. The NDHS 2006 reports that nearly 50 percent of girls are married by the age of 15, and 40 percent have their first child between the ages of 15 and 19, a period during which many women are not adequately prepared for motherhood, either physically or mentally. The contraceptive prevalence rate remains low at just 29 percent, and married teenagers are at a heightened risk of maternal mortality due to complications arising from pregnancy, childbirth, and unsafe abortion (MoH, 2006).

Each year, approximately 16 million adolescents give birth, accounting for 11% of all births globally. A significant 95% of these births take place in low and middle-income nations. Data collected from 51 countries between the mid-1990s and early 2000s revealed that by the age of 16, 10% of girls have already become mothers.[20] Teenage pregnancy presents significant risks for both the mother and the child due to their susceptibility to various health complications.[21] In Nepal, the incidence of stillbirths and preterm deliveries was greater among teenage mothers than among those who were older and more mature.[22]

Women belonging to the Dalit and Terai castes exhibit a higher likelihood of experiencing teenage pregnancies in comparison to women from other ethnic backgrounds ($p<0.05$). An analysis of the correlation between teenage pregnancy and women's highest level of education indicates that the incidence of teenage pregnancies diminishes as educational attainment rises ($p<0.001$). Additionally, the economic factor demonstrates a more pronounced relationship with teenage pregnancies ($p<0.001$). The prevalence of teenage pregnancy stands at 36.4%, which aligns closely with the 35% reported in Bangladesh.[24] However, the NDHS (2011) indicated that only 17% of teenage girls had either given birth or were pregnant with their first child. In contrast, the prevalence of teenage pregnancy in Sri Lanka is reported to be 8%, in India 21%.[25,26] The findings were less than those observed in our study. The correlation between teenage

pregnancy and the highest level of education attained by women indicated that the incidence of teenage pregnancies declines as educational attainment rises ($p<0.001$). The NDHS (2011) further revealed that women with a secondary leaving certificate (SLC) or higher typically initiate sexual activity four years later than their counterparts with no formal education. In a similar vein, fertility rates are inversely related to educational level, with an average of 3.7 births recorded among women lacking education, compared to 1.7 births among those with SLC or higher qualifications. The economic variable demonstrated a more significant correlation with teenage pregnancies ($p<0.001$). Research conducted in Nepal indicated that adolescents belonging to the highest wealth quartile initiate sexual activity approximately two years later than those in the lowest quartile, with ages of 19.3 years and 17.1 years, respectively. Nearly 90% of adolescent girls experience an unwanted pregnancy.[27] The research indicated that 36.4% of adolescent girls utilize condoms, a figure that is significantly lower than the 65% reported in a study conducted in the border region of Nepal (Ghubaju, 2002). Furthermore, this study revealed that economic factors exhibited a more pronounced correlation with teenage pregnancies ($p<0.001$). Data from Nepal demonstrated that adolescents belonging to the highest wealth quartile initiate sexual activity at least two years later than those in the lowest quartile, with ages of 19.3 years and 17.1 years, respectively.[28] Additionally, nearly 90% of adolescent girls experience unwanted pregnancies.[29] Teenage pregnancy accounts for 46.3% of unplanned pregnancies among adolescent girls.[30] The data were dependent on the secondary survey though it was country-representative data, limited resources were used to analyse the data even though huge resources were spent by the data collection agency. There may be the response bias and Hawthorne effect during the data collection. These are the limitations of this study.

CONCLUSION

Adolescent pregnancy remains a multifaceted and difficult challenge for families, healthcare professionals, educators, communities, governments, and the adolescents involved. Teenage pregnancy is correlated with the family's monthly income, the educational levels of both spouses and the husband’s occupation. A significant respondents reported experiencing their first pregnancy before the age of 19. Decisions regarding marriage were predominantly made by family members and the respondents themselves. Additionally, the primary reasons for unwanted pregnancies included a lack of awareness regarding their consequences, adherence to socio-cultural norms, and peer pressure. Among the respondents, condoms being the most commonly used method. Furthermore, participants were aware of the negative consequences associated with teenage pregnancy, with television and radio serving as the main sources of information.

Awareness interventions on dangerous signs during pregnancy, delivery, and post-partum period should be implemented at the community, harmful effects of teenage pregnancy should be included in the textbooks of primary and secondary school, age of marriage policy should be strongly implemented, and government should discourage social security facilities to the family having teenage pregnancy, girls education program should be implemented with national priority, social media should be mobilized in anti-teenage pregnancy campaign to control teenage pregnancy.

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