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Causes and effects of teenage pregnancies

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Abstract

Teenage pregnancy refers to female adolescents becoming pregnant between the ages of 13-19. These young females have not yet reached adulthood. Adolescent pregnancy is a global phenomenon with clearly known causes and serious health, social and economic consequences to individuals, families and communities. There is consensus on the evidence-based actions needed to prevent it. There is growing global, regional and national commitment to preventing child marriage and adolescent pregnancy and childbearing. Nongovernmental organizations have led the effort in several countries. In a growing number of countries, governments are taking the lead to put in place large-scale programmes. They challenge and inspire other countries to do what is doable and urgently needs to be done – now evidence shows that provision of incentives to promote adherence to medication is a promising strategy. For example, people could get money for transport or mobile data to get health information. This might promote access and consistent use of contraceptives among adolescent girls and young women. The study concludes that children need to grow up having a positive self-image as well as a healthy environment to grow up in. Children need unconditional love and support from their parents as it is critical in ensuring the child makes better choices about their future sexual activity. Having love from one's parents ensures that these adolescents are not left feeling unwanted from parents who are very passive and uninvolved. Documentary research approach, which consists of reviewing, analysing and examining information, recorded media and texts was adopted for the study.

Keywords: teenage pregnancies, contraceptives, child marriage, childbearing

Background

Pregnancies among adolescent girls remain a global problem. An estimated 21 million girls aged 15–19 years in developing countries become pregnant and about 12 million of them give birth every year (Akella and Jordan, 2011). Teenage pregnancy, also known as adolescent pregnancy, is pregnancy in a female under the age of 20, according to the WHO (Austin, 2011). Pregnancy can occur with sexual intercourse after the start of ovulation, which can be before the first menstrual period (menarche) but usually occurs after the onset of periods. In well-nourished girls, the first period usually takes place around the age of 12 or 13 (Austin, 2011). Pregnant teenagers face many of the same pregnancy related issues as other women. There are additional concerns for those under the age of 15 as they are less likely to be physically developed to sustain a healthy pregnancy or to give birth. For girls aged 15–19, risks are associated more with socioeconomic factors than with the biological effects of age. Risks of low birth weight, premature labor, anemia, and pre-eclampsia are connected to biological age, as they are observed in teen births even after controlling for other risk factors, such as access to prenatal care (Austin, 2010).

Teenage pregnancies are related to social issues, including lower educational levels and poverty (Austin, 2010). Teenage pregnancy in developed countries is usually

outside of marriage and is often associated with a social stigma. Teenage pregnancy in developing countries often occurs within marriage and half are planned (Austin, 2011). However, in these societies, early pregnancy may combine with malnutrition and poor health care to cause medical problems. When used in combination, educational interventions and access to birth control can reduce unintended teenage pregnancies. Adolescent pregnancy is a global phenomenon with clearly known causes and serious health, social and economic consequences. Globally, the adolescent birth rate (ABR) has decreased, but rates of change have been uneven across regions. There are also enormous variations in levels between and within countries. Adolescent pregnancy tends to be higher among those with less education or of low economic status. Further, there is slower progress in reducing adolescent first births amongst these and other vulnerable groups, leading to increasing inequity (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013). Child marriage and child sexual abuse place girls at increased risk of pregnancy, often unintended. In many places, barriers to obtaining and using contraceptives prevent adolescents from avoiding unintended pregnancies. There is growing attention being paid to improving access to quality maternal care for pregnant and parenting adolescents. WHO works with partners to advocate for attention to adolescent pregnancy, to build an evidence base for action, to develop policy and programme support tools, to build capacity and to support countries to address adolescent pregnancy effectively (Austin, 2010).

Scope of the problem

In 2015, about 47 females per 1,000 had children well under the age of 20. Rates are higher in Africa and lower in Asia (Austin, 2011). In the developing world about 2.5 million females under the age of 16 and 16 million females 15 to 19 years old have children each year. Another 3.9 million have abortions. It is more common in rural than urban areas. [Worldwide, complications related to pregnancy are the most common cause of death among females 15 to 19 years old (Austin, 2010).

As of 2019, adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended (Bolton, Walld, Chateau, Martens, Leslie, Enns , Sareen and Parental, 2013).

An estimated 21 million pregnancies occurred in 2016 among adolescent women aged 15–19 years in developing regions, where an estimated 12 million resulted in births (Austin, 2011).

Data on childbirths among girls aged 10–14 are not widely available; limited available data from Angola, Bangladesh, Mozambique and Nigeria point to birth rates in this age group exceeding 10 births per 1000 girls as of 2020 (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013).

Based on 2019 data, 55% of unintended pregnancies among adolescent girls aged 15–19 years end in abortions, which are often unsafe in LMICs (Akella and Jordan, 2011).

Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal condition.

Preventing pregnancy among adolescents and pregnancy-related mortality and morbidity are foundational to achieving positive health outcomes across the life course and imperative for achieving the Sustainable Development Goals (SDGs) related to maternal and newborn health.

As of 2019, an estimated 21 million girls aged 15–19 years in LMICs became pregnant (1). An estimated 12 million of these pregnancies resulted in births in 2016 (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013).

Globally, ABR has decreased from 64.5 births per 1000 women in 2000 to 42.5 births per 1000 women in 2021. However, rates of change have been uneven in different regions of the world with the sharpest decline in Southern Asia (SA), and slower declines in the Latin American and Caribbean (LAC) and sub-Saharan Africa (SSA) regions. Although declines have occurred in all regions, SSA and LAC continue to have the highest rates globally at 101 and 53.2 births per 1000 women, respectively, in 2021 (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013).

There are enormous differences within regions in ABR as well. In LAC, for example, Nicaragua recorded the highest estimated ABR at 85.6 per 1000 adolescent girls in 2021, compared to 24.1 per 1000 adolescent girls in Chile (Austin, 2011). Even within countries, there are enormous variations, for example in Zambia the percentage of adolescent girls aged 15–19 who have begun childbearing (women who either have had a birth or are pregnant at the time of interview) ranged from 14.9% in Lusaka to 42.5% in the Southern Province in 2018 (5). In Indonesia, this ranged from 3.5% in the Cordillera Administrative region to 17.9% in the Davao Peninsula region in 2017(Darroch , Woog , Bankole and Ashford, 2016).

While the estimated global ABR has declined, the actual number of childbirths to adolescents continues to be high. The largest number of estimated births to 15–19-year-olds in 2021 occurred in SSA (6 114 000), whereas far fewer births occurred in Central Asia (68 000). The corresponding number was 332 000 among adolescents aged 10–14 years in SSA, compared to 22 000 in South-East Asia (SEA) in the same year (Austin, 2011). South Africa recorded increased rates of teenage pregnancies in some parts of the country between 2018 and 2019 and more recently during the COVID-19 pandemic. This was partly due to the difficulty of accessing contraceptives, which was greater during the COVID-19 lockdown (Akella and Jordan, 2011). An increase in the adolescent pregnancy rate strongly suggests challenges with accessing sexual and reproductive healthcare services for this vulnerable age group and is a cause for concern

Main Causes/Factors Contributing to Teenage Pregnancy:

- Lack of parental care
- Lack of formal and informal education
- Lack of sex education
- Insufficient communication and supervision by parents.
- Poverty
- Peer pressure
- Low educational level
- Negative family interactions
- Single parent families
- Sexual abuse or Rape
- Substance abuse
- Socio-economic status

- Family history of teenage pregnancies
- Forced marriage
- Child marriage
- Lack of school fees
- Desire for children
- Insufficient knowledge of contraceptive devices (Akella and Jordan, 2011:65)

Peer Pressure and Sexual Abuse

Peer pressure is another major cause of sexual abuse, often females may be pressured or forced by an older male partner to engage in sexual activity. These young females out of fear may feel forced to engage in unprotected sex without a choice (Akella and Jordan, 2011).

Peer pressure may also be prevalent in a different form while in relationships adolescents may be pressured by their partner to have unsafe and unprotected sex in order to express their "love" and "true feelings" for their partner. The partner may manipulate the other to have unprotected sex which leads to unintended pregnancy (Akella and Jordan, 2011)

Sexual abuse is also another reason why teens may become pregnant. Early sexual abuse has been linked to later teen pregnancies. Some children have unfortunately been sexually abused my predators or even family even prior to entering puberty. These young kids often are unable to inform a trusted adult about the situation due to fear of being harmed by their predator. These situations, further effect the child as they enter adolescence and increases chances of teen pregnancy.

Media Influence

The media has a large effect on teen pregnancy, especially shows such as "Teen Mom" and "16 and Pregnant". These shows often glamorize pregnancy and hide the true hardships associated with pregnancy which encourages these teens to become pregnant. Some teenage females become pregnant just so they are able to drop out of high school or to force their partners into a deeper commitment (Austin, 2011). Rebellion is also another reason why some teens will become pregnant. In order to show their independence and deem themselves as having more control over their lives, a teen may decide to have a child. These television glorify the idea of having a child through the promotion of these teenagers having a more adult lifestyle, with more responsibility and decision-making power (Austin, 2011).

Approximately 90% of births to girls aged 15-19 in developing countries occur within early marriage where there is often an imbalance of power, no access to contraception and pressure on girls to prove their fertility. Factors such as parental income and the extent of a girl's education also contribute. Girls who have received minimal education are 5 times more likely to become a mother than those with higher levels of education. Pregnant girls often drop out of school, limiting opportunities for future employment and perpetuating the cycle of poverty. In many cases, girls perceive pregnancy to be a better option than continuing their education (Austin, 2011).

In addition, the unique risks faced by girls during emergencies increase the chances of them becoming pregnant. Factors include the desire to compensate for the loss of a child, reduced access to information and contraception and increased sexual violence.

Mothers and older sisters are the main sources of family influence on teenage pregnancy; this is due to both social risk

and social influence. Family members both contribute to an individual's attitudes and values around teenage pregnancy, and share social risks (such as poverty, ethnicity, and lack of opportunities) that influence the likelihood of teenage pregnancy (Austin, 2010). Having an older sister who was a teen mom significantly increases the risk of teenage childbearing in the younger sister and daughters of teenage mothers were significantly more likely to become teenage mothers themselves. Girls having both a mother and older sister who had teenage births experienced the highest odds of teenage pregnancy, with one study reporting an odds ratio of 5.1 (compared with those who had no history of family teenage pregnancy (Darroch , Woog , Bankole and Ashford, 2016). Studies consistently indicate that girls with a familial history of teenage childbearing are at much higher risk of teenage pregnancy and childbearing themselves, but methodological complexities have resulted in inconsistent findings around "parent/child sexual communication and adolescent pregnancy risk" (Austin, 2010) .A review of family relationships and adolescent pregnancy risk found risk factors to include living in poor neighborhoods and families, having older siblings who were sexually active, and being a victim of sexual abuse (Austin, 2011). Research around the impact of sister's teenage pregnancy has been limited to mostly qualitative studies using small samples of minority adolescents in the United States (Akella and Jordan, 2011).

Several examinations of family histories in the literature show older sisters to have the greatest influence on a younger sister's odds of having a teenage pregnancy. Controlling for family socioeconomic status, maternal parenting, and sibling relationships, teens with an older sister who had a teenage birth were 4.8 times more likely to have a teenage birth themselves; these odds increased to 5.1 if both the older sister and mother had a teenage birth (Austin, 2010). Four older studies estimated the rate of teen pregnancy to be between 2 and 6 times higher for those with older sisters having a teenage pregnancy. This work focused primarily on young black women in the United States and controlled for limited confounders (aside from race and age). None of the previous studies examining the impact of an older sister's teenage pregnancy controlled for mother's teenage childbearing or time-varying factors before age 14 (mental health, residential mobility, family structure changes); this research probably overestimated the relationship between sisters' teenage pregnancy status (Akella and Jordan, 2011).

The mechanisms driving the relationship between an older sister's teenage pregnancy and the pregnancy of a younger adolescent sister have been examined through approaches based on social learning theory, shared parenting influences, and shared societal risk (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013). Bandura's social learning theory indicates that "most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action" . When sisters live in the same environment, seeing an older sister go through a teenage pregnancy and childbirth may make this a more acceptable option for the younger sister (Austin, 2011). Not only do both sisters have the same maternal influence that may affect their odds of teenage pregnancy, having an older sister who is a teenage mother may change the

parenting style of the mother. Mothers involved in parenting of their teenage daughters' child may have "supervised their children less, communicated with their children less about sex and contraception, and perceived teenage sex as more acceptable when the older daughter's status changed from pregnant to parenting". Finally, both sisters share the same social risks, such as poverty, ethnicity, and lack of opportunities, that increase their chances of having a teenage pregnancy (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013).

Intergenerational teenage pregnancy may be influenced by such mechanisms as "biological heritability, intergenerational transmission of values regarding family, the mother's level of fertility, the indirect impact of socioeconomic and family environment through educational deficits or low opportunity or aspirations, and directly through the mother's role modeling" (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013). Women bearing their first child in their adolescence are more likely to pass on "risky" characteristics, which could produce negative outcomes in their offspring. Another mechanism identified as contributing to intergenerational teenage pregnancy is that daughters of teenage mothers have an increased internalized preference for early motherhood, have low levels of maternal monitoring, and are thus more likely to become sexually active at a young age and engage in unprotected sex (Darroch , Woog , Bankole and Ashford, 2016). The influence of a mother's teenage pregnancy therefore works through the environment created and parenting style assumed as a result of a mother's teenage childbearing.

- Even before the pandemic, in South Africa, 16% of young women aged 15-19 had begun childbearing. The figure ranges between 11% in urban areas and 19% in rural areas (Akella and Jordan, 2011)
- One factor that has contributed to this is violence against women and girls. In South Africa one in three women experience gender based-violence and one in five children under the age of 18 experience sexual abuse.
- Deficiencies in the health system also contribute to teenage pregnancies. It's not always easy for adolescents to get contraceptives if services aren't youth-friendly.
- Education about contraception for adolescents is inadequate too.
- In South Africa, 31% of girls aged 15 to 19 aren't getting the contraceptives they need – a bigger proportion of this age group than other age groups (Akella and Jordan, 2011:65).

The study by Austin established that adolescent girls and young women have a high-unmet need for contraception and that health system barriers to contraception services persist. Only 48% of the respondents said they had ever used a modern contraceptive. Use of condoms the last time the respondents had sex was reported by 51% (Austin, 2011). This means half of the adolescent girls and young women were at risk of being infected with HIV or any sexually transmitted infection, or passing an infection on. Interviews revealed that many young women, especially in the age group 15–19 years, found it difficult to get contraceptives. We found that they did not

have information about contraceptives. Many did not know how the different methods work and affect the body. Some believed that contraceptives were not good for the body, based on myths and misinformation. Some believed contraceptives did not work at all (Austin, 2011).

Some of the respondents said contraception would ruin their wombs and, in the future, they would not be able to have children. Many lacked support to use contraceptives from parents or other caregivers (Austin, 2011):

- They said that health workers asked them embarrassing questions and mistreated them:
- The nurses will start asking all sorts of questions; why are you here? Young as you are! Do you have a boyfriend? And because of these questions and that you feel embarrassed you end up leaving without accessing the services …
- They won't speak to you privately in a room, instead they will loudly say why are you here for contraceptives in front of people and you can imagine how many people are at the clinic.

In the second survey by Austin, among those who reported they had sex in the year before the survey, only 28% reported using contraceptives consistently (Austin, 2011). The reasons included disliking the side effects; running out of contraceptives; inconvenient health service opening hours; stock-outs at the health service; and the COVID-19 pandemic. During the past year 22% of the respondents said they had been unable to get the contraceptives they needed. And 21% reported challenges getting condoms because of COVID-19 and the lockdown (Akella and Jordan, 2011)

Context in which adolescent pregnancies occur

Studies of risk and protective factors related to adolescent pregnancy in LMICs indicate that levels tend to be higher among those with less education or of low economic status. Progress in reducing adolescent first births has been particularly slow amongst these vulnerable groups, leading to increasing inequity (Austin, 2011).

Several factors contribute to adolescent pregnancies and births. First, in many societies, girls are under pressure to marry and bear children. As of 2021, the estimated global number of child brides was 650 million: child marriage places girls at increased risk of pregnancy because girls who are married very early typically have limited autonomy to influence decision-making about delaying child-bearing and contraceptive use Second, in many places, girls choose to become pregnant because they have limited educational and employment prospects. Often in such societies, motherhood – within or outside marriage/union – is valued, and marriage or union and childbearing may be the best of the limited options available to adolescent girls (Austin, 2010).

Contraceptives are not easily accessible to adolescents in many places. Even when adolescents can obtain contraceptives, they may lack the agency or the resources to pay for them, knowledge on where to obtain them and how to correctly use them. They may face stigma when trying to obtain contraceptives. Further, they are often at higher risk of discontinuing use due to side effects, and due to changing life circumstances and reproductive intentions (Austin, 2010). Restrictive laws and policies regarding the provision of contraceptives based on age or marital

status pose an important barrier to the provision and uptake of contraceptives among adolescents. This is often combined with health worker bias and/or lack of willingness to acknowledge adolescents' sexual health needs.

Child sexual abuse increases the risk of unintended pregnancies. A WHO report dated 2020 estimates that 120 million girls aged under 20 years have experienced some form of forced sexual contact. This abuse is deeply rooted in gender inequality; it affects more girls than boys, although many boys are also affected. Estimates suggest that in 2020, at least 1 in 8 of the world's children had been sexually abused before reaching the age of 18, and 1 in 20 girls aged 15–19 years had experienced forced sex during their lifetime (Akella and Jordan, 2011).

The WHO report titled Violence against women prevalence estimates 2018 notes that "adolescents aged 15–19 years (24%) are estimated to have already been subjected to physical and/or sexual violence from an intimate partner at least once in their lifetime and 16% of adolescent girls and young women aged 15–24 have been subjected to this violence within the past 12 months." (Austin, 2010).

Preventing adolescent pregnancy and childbearing as well as child marriage is part of the SDG agenda with dedicated indicators, including indicator 3.7.2, "Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group," and 5.3.1, "Proportion of women aged 20–24 years married before the age of 18 years (Austin, 2011).

Strategies and interventions related to adolescent pregnancy have focused on pregnancy prevention. However, there is growing attention being paid to improving access to and quality of maternal care for pregnant and parenting adolescents. Available data on access paints a mixed picture. Access to quality care depends on the geographic context and the social status of adolescents. Even where access is not limited, adolescents appear to receive a lower quality of both clinical care and interpersonal support than adult women do Chung, Kim and Lee, 2018).

Adverse Effects of Teenage Pregnancy:

- High social and economic costs of teen pregnancy and childbearing can have short and long-term negative consequences for teen parents, their children, and their community.
- High risk of Low Birth Weight (LBW) child
- High chances of premature infants
- Anemia
- Pre-eclampsia
- High risk of Infant mortality
- Drop out of school
- Lower school accomplishment
- Unemployment/ underemployment as a young adult
- Lack of proper emotional support and cognitive stimulation by the children who are born to teen mothers.
- Behavioral problems and chronic medical conditions of the children
- Higher chances of foster care settlement of the children.
- Teen mom goes through various mental stress due to unplanned pregnancy such as:
- Sleepless nights
- Insomnia

- High chances of postpartum depression
- Baby blues: Woman experiences symptoms like mood swings, anxiety, sadness, overwhelm, difficulty concentrating, trouble eating, and difficulty sleeping for one to two weeks after giving birth which collectively known as 'Baby Blues'.
- More chances to experience posttraumatic stress disorder (PTSD) that includes more severe and significant symptoms than baby blues. Likewise, the teen mom can have additional symptoms of postpartum depression like-
- Difficulty bonding with baby
- Overwhelming fatigue
- Feeling of worthless
- Anxiety
- Panic attacks
- Thinking of harming own self or the baby
- Difficulty in enjoying activities Chung, Kim and Lee, 2018:65).

Adolescent pregnancy remains a major contributor to maternal and child mortality. Complications relating to pregnancy and childbirth are the leading cause of death for girls aged 15-19 globally. Pregnant girls and adolescents also face other health risks and complications due to their immature bodies. Babies born to younger mothers are also at greater risk (Darroch , Woog , Bankole and Ashford, 2016).

For many adolescents, pregnancy and childbirth are neither planned, nor wanted. In countries where abortion is prohibited or highly restricted, adolescents typically resort to unsafe abortion, putting their health and lives at risk. Some 3.9 million unsafe abortions occur each year to girls aged 15-19 in developing regions (Akella and Jordan, 2011).

Adolescent pregnancy can also have negative social and economic effects on girls, their families and communities. Unmarried pregnant adolescents may face stigma or rejection by parents and peers as well as threats of violence. Girls who become pregnant before age 18 are also more likely to experience violence within a marriage or partnership.

Teenage births result in health consequences; children are more likely to be born pre-term, have lower birth weight, and higher neonatal mortality, while mothers experience greater rates of post-partum depression and are less likely to initiate breastfeeding (Akella and Jordan, 2011). Teenage mothers are less likely to complete high school, are more likely to live in poverty, and have children who frequently experience health and developmental problems. Understanding the risk factors for teenage pregnancy is a prerequisite for reducing rates of teenage motherhood. Various social and biological factors influence the odds of teenage pregnancy; these include exposure to adversity during childhood and adolescence, a family history of teenage pregnancy, conduct and attention problems, family instability, and low educational achievement (Akella and Jordan, 2011).

Pregnancies not only have adverse health risks for adolescent mothers and their babies – these problems can persist into the next generation. For example, girls who become pregnant often drop out of school, limiting their future economic opportunities and perpetuating a cycle of poverty (Akella and Jordan, 2011).

The research that has examined the impact of adolescent childbearing on the family has generally taken three forms: the effects of teenage childbearing on a family's intergenerational structure, whereby a history of early parenting creates an age-condensed multigenerational family structure (Akella and Jordan, 2011); its effects on family residential patterns and household composition (e.g., (Austin, 2011). This last area of research has examined the quality of grandmothers' parenting (Chase-Lansdale, Brooks-Gunn, & Zamsky, 1994) and its relation to outcomes of the teen's child (Spieker & Bensley, 1994) and to qualities of the adolescent's parenting (East & Felice, 1996). What these studies lack, however, is an analysis of how families change or adapt specifically in response to a teenager's pregnancy and birth.

Families in which teenagers bear children have historically been characterized by grandparental childrearing systems, wherein the adolescent's mother typically provides the primary hands-on care for the teen's child (Burton, 1995, 1996a, 1996b). Because these grand parenting duties can be extensive and time consuming, they likely interfere with or distract the mother from monitoring or supervising her own children. Role strain theory postulates that the psychological stress associated with undertaking multiple roles impedes a person from performing well in any role (Goode, 1960). Thus, it may be that the time and role demands of caring for her daughter's child compromises a mother's ability to monitor her own children's behavior and activities.

It is also conceivable, however, that because of the older daughter's early pregnancy or birth, mothers might be even more rigorous in monitoring their other children (Austin, 2011). Although this possibility will be examined in the study presented here, the more practical responsibilities of caring for her daughter's child probably would diminish a mother's ability to oversee her own children's activities, especially given that most of these mothers are parenting (and grandparenting) alone without a coresident adult (Burton, 1995) and that the mother's other children are likely to be adolescents and monitoring their behavior is particularly difficult (Dornbusch et al., 1985).

Mothers

Due to becoming pregnant during adolescence, teen mothers are very likely to drop out of school because of their low ambitions and dedication to getting an education. About 38% of female teens who have a child before the age of 18 complete their highschool education by the age of 22 (Austin, 2011). This means that a very high percentage of teen mothers will not even go on to graduate from high school let alone pursue post-secondary education (Austin, 2011). In light of this, these young girls do not have full qualifications for proper jobs in the future, which leads to having a job with very low wages or even worse, unemployment. Further, this leads to poor living conditions and the inability to maintain a safe and clean environment for their newborn child. These young women often end up living on welfare and do not have adequate resources for their child. Overall, these young girls are forced to delay and postpone any plans for their future in order to raise their child (Austin, 2011)

Another issue associated with teen pregnancy is the young mother is often forced to essentially give up her identity for a new one while switching into a maternal

role. These young mothers go through many physical changes: from adolescent physical adjustment to having to adapt to the ever changing shape of her body through the pregnancy and her postpartum figure. Teens are often forced to become reliant on their family for financial resources as well as support to help get her through raising a child. In some cases, teens are shunned by their parents and do not even receive any support from their parents who are not accepting of the pregnancy. These young girls are often forced to lose contact with friends and others in their social groups in order to focus on their pregnancy (Austin, 2010).

Pregnant teens often do not have the proper healthy habits in order to go through a successful child rearing process. These mothers thus have heightened health risks, which inhibits healthy child development. Young women can suffer from things such as anaemia as well as blood pressure which is only possible during pregnancy (Akella and Jordan, 2011). These mothers often smoke and drink because they are not properly educated on the child rearing process.

Having a child during these essential years truly clashes with the developmental tasks that should be occurring during adolescents. These young mothers are unable to fully develop a sense of self-identity because of their new role as an expecting mother. Further, peer and social relationships are strained or even terminated and teen years are essentially for developing relationships with others and discovering oneself (Austin, 2010). Due to all of these factors, teen mothers may end up developing depression after essentially being alienated from their family and friends. These symptoms of depression increase the chances of the teen mother committing suicide (Austin, 2010).

Pursuing this further, teen mothers are often strained for resources and social support from the father of the child. In some cases, the teen father will remain present throughout the process and in others the father will not (Austin, 2011). If the father remains present there is often high relationships tension and dissatisfaction because of the lack of financial resources, support and child care which will be needed. There is an increase in conflict which may lead to breakups, leaving the mother to be a single parent or even violence within the relationship (Akella and Jordan, 2011). Due to the lack of financial resources, these young women often do not get prenatal checkups or regular checkups for their developing child and thus they are unaware of any health concerns for their child.

Many of these teen mothers are not healthy enough, thus they have a higher risk for obstructed labour and also these young women often undergo unsafe abortions which lead to the death of many young females and their unborn child (Austin, 2011).

Child

The child of a teen mother is very likely to live in poverty because of its mothers lack of financial resources. Essentially, the birth of this child becomes the beginning of a perpetual cycle in many cases. The child is likely to endure many of the same issues its mother did in her childhood (Austin, 2011). For instance, the child is likely to grow up in poverty and in very poor conditions. They are likely to be missing a father figure, leaving them with fewer role models and increased chances of confiding in other children in the same situation. The

children's academic success is also further compromised and these children do not strive to achieve much academically (Austin, 2010). Furthermore, these kids have social problems and are unable to make friends very easily which leads to poor relationship development which is a crucial stage in adolescence. Poor relationship development can be linked to the child being deprived economically as well as educationally. The children are likely to drop out of high school and also succumb to the use of drugs and alcohol due to lack of parental involvement and monitoring. The cycle is very likely to repeat itself over and over (Austin, 2010).

The children are often also likely to suffer health risks in comparison to those born to adults. They are likely to be cognitively impaired and also susceptible to behavioural issues. The children are likely to be born underweight and prematurely, which is detrimental to their health and may even result in infant mortality (Bolton, Walld, Chateau, Martens, Leslie , Enns , Sareen and Parental, 2013).

Some reasons teens may have sex at a young age are:

- Pressure from an older boy or girlfriend to have sex
- The media often conveys the idea that teen sex is common and acceptable
- Teens often do not get good information about sex, relationships, and values from reliable sources, such as parents. They may feel embarrassed and don't want to ask parents questions
- For girls, a belief that having sex will give them emotional intimacy
- For boys, a belief that having sex will give them higher social status with their peers
- Teens who feel pressured to have sex because "everyone is doing it" should know that more than half of teens wait until they are older to have sex (Stayteen.org, 2014:78).

Why some teens want to get pregnant (Akella and Jordan, 2011)

Many teen girls come from lower income groups and don't expect much from their future. Many have boyfriends 5 or more years older than themselves and are more vulnerable to coercion to have sex. Their reasons for wanting a baby may vary, but often include:

- They think somehow it will stop their boyfriend from leaving them – however most teen mothers do end up being single
- They can romanticize about having a baby
- They believe being a mother will give them a sense of fulfilment
- They don't see any better options for their future than getting pregnant and dropping out of school
- They think having a baby seems like a good alternative to finishing school
- Why teens have unprotected sex
- Many unplanned teen pregnancies are the result of unprotected sex. Ninety percent of teens having unprotected sex will get pregnant within a year (Habib, 2006).
- There are a number of reasons that teens may have unprotected sex:

- They feel like pregnancy and STIs are things that only happen to other people, though each year nearly 1 million teen girls get pregnant and nearly 10 million teen boys and girls get STIs from unprotected sex
- One or both teens used drugs or alcohol before sex
- They don't know the risks of unprotected sex
- They are not emotionally mature enough to make safer choices about sex
- They may feel on the outer and believe that "everyone's doing it"
- They feel pressured by their partner to have unprotected sex (Habib, 2006)
- They feel embarrassed about asking for or buying contraception
- Risk factors for teen sexually activity and teen pregnancy include:
- Using alcohol, drugs, or tobacco
- Dropping out of school, or not having a commitment to education
- Having little social support, such as caring family or friends
- Not feeling involved with family, school, or community
- Feeling like they have no opportunities, or not recognizing their own potential
- Being in an environment where teen pregnancy is common
- Living in poverty
- Being a victim of sexual abuse
- Being the child of a teen mother
- Suffering from depression or other mental health problems (Teen Pregnancy Statistics, 2009)

Pregnancy Proneness – predisposing features

There is a whole cluster of issues that may predispose a teenager to an unplanned pregnancy (Austin, 2011):

- family situations with regular conflict between members
- family violence or sexual abuse during childhood
- unstable housing arrangements
- living in out of home care
- poor school performance and attendance
- low socio-economic background
- family history of pregnancies at a young age
- low level of maternal education
- low self-esteem
- undisclosed same-sex attraction
- Aboriginal or Torres Strait Islander status
- living in rural and remote areas
- having a mental health diagnosis
- (Better Health Channel, 1999/2014).

Conclusion

When an adolescent becomes pregnant and bears a child, it is reasonable to expect that this affects the adolescent's family, if only because the new baby often becomes part of the family household and requires a

great deal of care and attention. But how adolescent childbearing impacts the adolescent's family of origin, particularly her parents' parenting and her siblings' development, has been a completely neglected area of study. Open communication and time spent with children is a protective factor against teen pregnancy also. Children and teens should be able to approach their parents and ask for their time whenever in need. Developing a strong relationship between child and parent is critical. These children are more likely to use birth control or other contraceptives and make better decisions in regards to sexual behaviours .

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