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EFFECTS OF TEENAGE PREGNANCY ON GIRL'S EDUCATION: A CRITICAL REVIEW

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2. ABSTRACT

Teenage pregnancy is an important social, educational and public-health concern because it can interrupt girls' schooling and restrict later opportunities. This seminar examined its reported effects on school attendance, academic performance, school continuation and re-entry, social and emotional experiences, and future educational and employment prospects. The manuscript describes a mixed-methods, descriptive study involving 30 respondents selected purposively. The stated data-collection methods were questionnaires, interviews and documentary sources, while quantitative results were summarised using frequencies and percentages. The reported findings indicate that 46.7% of respondents were aged 18–19 years and 60.0% were single. Thirteen respondents (43.3%) were reported as having dropped out of school; 80.0% said they had stopped attending temporarily or permanently because of pregnancy. Fear of ridicule was the most frequently reported reason for missing school during pregnancy (40.0%). Among the reasons recorded for not returning after childbirth, childcare (43.3%) and lack of family support (36.7%) were prominent, although the denominator used for this table requires verification. Academic performance reportedly worsened for 46.7%, and half reported difficulty concentrating. The findings suggest that pregnancy and early motherhood may create educational barriers through interrupted attendance, stigma, financial constraints and care responsibilities. The report recommends effective school re-entry implementation, counselling, family and community support, academic catch-up assistance and practical childcare support. Because the sample is small and some table denominators and respondent categories are unclear, the results should be interpreted as descriptive findings from the 30 participants rather than population estimates or proof of causation.

Word count: approximately 220.

3. KEYWORDS: Teenage pregnancy; girls' education; school attendance; academic performance; school dropout; school re-entry.

4. INTRODUCTION

4.1 Background

Teenage pregnancy refers to pregnancy occurring during adolescence. In this report, the term is used broadly for pregnancy among girls and young women below 20 years, while recognising that public-health reporting often distinguishes the age groups 10–14 and 15–19. Adolescence is an important period for educational development, skills acquisition and preparation for adult life. Pregnancy and early motherhood during this period can introduce health, social, financial and caregiving demands that may compete with school attendance and study time.

Education equips girls with literacy, numeracy, knowledge and transferable skills. It can strengthen their capacity to make informed decisions, participate in community life and pursue further training or employment. When pregnancy occurs during schooling, the learner may face interruptions associated with antenatal care, physical discomfort, childbirth and recovery. Following childbirth, the demands of infant care can make it difficult to attend lessons, complete assignments and prepare for assessments. These challenges do not affect every learner in the same way: outcomes depend on family circumstances, school practices, household resources, community attitudes and the availability of support.

The World Health Organization (WHO, 2024) identifies adolescent pregnancy as a continuing global health and development concern. Its 2024 fact sheet reports that adolescent pregnancy is more common among girls with less education and those experiencing poverty, while also emphasising substantial differences between and within regions. WHO's estimates indicate that sub-Saharan Africa continues to experience a comparatively high adolescent birth rate. These patterns underline the importance of addressing the educational and social conditions associated with early pregnancy, rather than treating pregnancy as an isolated individual event.

In Zambia, adolescent childbearing varies substantially by province. WHO (2024), drawing on 2018 national data, reports that the proportion of girls aged 15–19 who had begun childbearing ranged from 14.9% in Lusaka Province to 42.5% in Southern Province. These figures are historical and should not be interpreted as current prevalence estimates. More recently, the Zambian Ministry of Education, with support from UNESCO, launched revised School Re-Entry Policy Guidelines in March 2026. The guidelines are intended to strengthen

implementation of the existing policy and support learners who leave school because of early and unintended pregnancy to return and complete their education (UNESCO, 2026).

4.2 Statement of the Problem

Although pregnancy should not automatically end a girl's education, pregnant learners and teenage mothers may encounter several obstacles to continuing school. These include health-related absence, fear of ridicule, discriminatory treatment, inability to pay school-related costs, childcare responsibilities and inadequate family support. Some learners may return after childbirth, while others may remain out of school. Where school re-entry arrangements exist but are poorly understood or inconsistently implemented, the formal right to return may not translate into practical access to learning.

The central problem addressed in this seminar is the extent to which teenage pregnancy is associated with interrupted school attendance, perceived decline in academic performance, school dropout and difficulties returning to education. The report also considers the social and emotional challenges that may shape educational experiences and the support measures that can help girls continue learning.

4.3 Significance of the Study

The study is relevant to learners and teenage mothers because it draws attention to barriers that may be addressed through practical support. Parents and guardians may use the findings to understand the importance of encouragement, childcare assistance and continued educational investment. Teachers and school administrators may use the findings to strengthen guidance, confidentiality, anti-bullying measures and academic catch-up arrangements. Social workers, health personnel, community organisations and policy-makers may use the findings to coordinate referrals and improve implementation of school re-entry measures. The study may also provide a starting point for further research, subject to the limitations of its sample and data documentation.

4.4 Theoretical Framework

The report is informed by human capital theory and ecological systems theory. Human capital theory explains education as an investment in knowledge and skills that can improve productivity and future economic opportunities (Becker, 1964). From this perspective, prolonged school interruption may reduce opportunities to acquire qualifications and skills. However, the theory should not be used to suggest that teenage mothers have lost their potential; rather, it highlights the value of ensuring that they can continue investing in their education.

Ecological systems theory emphasises that development is shaped by interactions between individuals and the environments in which they live (Bronfenbrenner, 1979). Applied to this topic, a learner's educational pathway may be influenced by family support, peer attitudes, school rules and practices, health services, community norms and national education policies. This framework helps explain why school re-entry requires coordinated action rather than relying solely on the young mother.

4.5 Aim and Objectives

The general objective was to examine the effects of teenage pregnancy on girls' education.

The specific objectives were to: (i) examine the effects of teenage pregnancy on school attendance; (ii) assess its reported effects on academic performance; (iii) examine its relationship with school dropout and return to school; (iv) identify social and emotional challenges experienced by girls who become pregnant while at school; (v) consider possible implications for future education and employment; and (vi) identify measures that can support pregnant learners and teenage mothers to continue their education.

5. MATERIALS AND METHODS

5.1 Study Design

The report describes a descriptive study using quantitative and qualitative approaches. A descriptive design is suitable for documenting reported experiences, patterns and perceptions without claiming that the design establishes causal relationships. The quantitative component was intended to summarise responses numerically, while the qualitative component was intended to provide context about stigma, support and school re-entry. This combination is consistent with mixed-methods research principles (Creswell, 2014).

5.2 Study Population and Target Participants

The stated target participants included teenage mothers, female learners, teachers, parents or guardians, social workers and other individuals with relevant knowledge of teenage pregnancy and girls' education. Teenage mothers could describe their experiences directly, while teachers, parents and social workers could provide contextual perspectives. The manuscript supplied for editing does not state the number of participants in each category. This information should be added from the original field records before journal submission.

5.3 Sampling Procedure and Sample Size

Purposive sampling was reported as the sampling procedure. Participants were selected because they were considered to have relevant experience or knowledge of the subject. Purposive sampling is appropriate for reaching information-rich participants, but it does not

produce a statistically representative sample of all teenage mothers or learners (Etikan et al., 2016). The total sample comprised 30 respondents.

5.4 Data Collection Instruments and Procedures

The supplied report identifies questionnaires and interviews as the primary instruments. The questionnaire reportedly contained closed-ended questions, while interviews were intended to obtain fuller accounts of participants' experiences. Documentary sources, including books, academic articles and publications from organisations such as WHO, UNICEF and UNESCO, were also consulted. The exact fieldwork dates, study location, questionnaire administration procedure, interview duration and number of interviews were not provided in the supplied manuscript and should be inserted only after checking the original records.

5.5 Data Analysis

Quantitative data were reportedly analysed using the Statistical Package for the Social Sciences (SPSS), with results presented as frequencies and percentages. Qualitative responses and documentary evidence were used to contextualise the numerical patterns. For each table, the percentage should be calculated using the number of valid responses to that question as the denominator. Where questions were answered only by a subgroup, the table must identify that subgroup and its valid sample size.

5.6 Ethical Considerations

Participants were reportedly informed about the purpose of the study and participation was voluntary. Confidentiality and respectful treatment are particularly important because pregnancy among adolescents may involve sensitive personal experiences and, for participants below 18 years, additional safeguarding requirements. Before submission, the author should confirm the institution's ethics approval or permission arrangements, informed-consent procedures, assent and parental/guardian consent where required, referral procedures for distress or safeguarding concerns, and the measures used to protect identifying information. The present manuscript does not provide an ethics approval number; none has therefore been invented.

6. RESULTS AND DISCUSSION

6.1 Presentation of Results

A total of 30 respondents were included in the reported dataset. The tables below reproduce the frequencies and percentages supplied in the original manuscript. The accompanying interpretations are descriptive and should be read in light of the limitations identified in Section 6.3.

Table 1. Age group of respondents. (n = 30)

Age group	Frequency	Percent
Below 15 years	4	13.3
15–17 years	8	26.7
18–19 years	14	46.7
20 years and above	4	13.3
Total	30	100.0

Fourteen respondents (46.7%) were aged 18–19 years, the largest age category. Eight (26.7%) were aged 15–17, while four (13.3%) were below 15 and four (13.3%) were 20 years or older. The distribution indicates that the sample included respondents across several age groups; it should not be treated as a population age profile.

Table 2. Marital status of respondents. (n = 30)

Marital status	Frequency	Percent
Single	18	60.0
Married	9	30.0
Divorced	2	6.7
Widowed	1	3.3
Total	30	100.0

Eighteen respondents (60.0%) were single, nine (30.0%) married, two (6.7%) divorced and one (3.3%) widowed. Marital status may shape access to support, but these figures alone do not show whether a respondent received practical or financial assistance from a partner or family.

Table 3. Highest level of education of respondents. (n = 30)

Education level	Frequency	Percent
No formal education	9	30.0
Primary education	14	46.7
Secondary education	7	23.3
Total	30	100.0

Fourteen respondents (46.7%) reported primary education as their highest level, nine (30.0%) no formal education and seven (23.3%) secondary education. These figures describe the sample's reported educational attainment. They do not establish that pregnancy alone caused the observed education levels.

Table 4. Current education status of respondents. (n = 30)

Education status	Frequency	Percent
Currently in school	7	23.3
Dropped out of school	13	43.3
Returned to school after pregnancy	10	33.3
Total	30	100.0

Thirteen respondents (43.3%) were classified as having dropped out, ten (33.3%) as having returned after pregnancy and seven (23.3%) as currently in school. The categories require checking because 'currently in school' may overlap conceptually with 'returned to school after pregnancy'. They should be mutually exclusive only if the questionnaire defined them that way.

Table 5. Age at first pregnancy. (n = 30)

Age at first pregnancy	Frequency	Percent
Below 15 years	9	30.0
15–17 years	18	60.0
18–19 years	2	6.7
Not applicable	1	3.3
Total	30	100.0

Eighteen respondents (60.0%) reported first pregnancy at ages 15–17, nine (30.0%) below age 15 and two (6.7%) at ages 18–19; one response was not applicable. The number reporting pregnancy below age 15 makes safeguarding, access to age-appropriate health information and appropriate referral pathways especially important.

Table 6. Whether teenage pregnancy affected school attendance. (n = 30)

Response	Frequency	Percent
Yes	19	63.3
No	11	36.7
Total	30	100.0

Nineteen respondents (63.3%) said pregnancy affected school attendance, compared with 11 (36.7%) who said it did not. This indicates that a majority of the sample perceived an attendance effect, although the table does not identify the specific form or duration of the interruption for each respondent.

Table 7. Whether respondents stopped attending school because of pregnancy. (n = 30)

Response	Frequency	Percent
Yes, temporarily	12	40.0
Yes, permanently	12	40.0
No, continued attending	6	20.0
Total	30	100.0

Twelve respondents (40.0%) temporarily stopped attending school and another 12 (40.0%) stopped permanently, while six (20.0%) continued. Thus, 24 of 30 respondents (80.0%) reported some interruption. Temporary interruption can delay progression, while permanent withdrawal may limit access to qualifications unless alternative learning or re-entry pathways are available.

Table 8. Main reason for missing school during pregnancy. (n = 30)

Reason	Frequency	Percent
Sickness or health problems	7	23.3
Fear of being laughed at by other learners	12	40.0
Lack of money for school requirements	5	16.7
Pregnancy-related responsibilities	6	20.0
Total	30	100.0

Twelve respondents (40.0%) identified fear of being laughed at as the main reason for missing school. Health problems were reported by seven (23.3%), pregnancy-related responsibilities by six (20.0%) and lack of money for school requirements by five (16.7%). Stigma was the most frequently selected response, highlighting the importance of respectful school environments and anti-bullying measures.

Table 9. Whether respondents returned to school after childbirth. (n = 30)

Response	Frequency	Percent
Yes	17	56.7
No	13	43.3
Total	30	100.0

Seventeen respondents (56.7%) reported returning to school after childbirth, while 13 (43.3%) did not. The result shows both the possibility of re-entry and the persistence of barriers for a substantial proportion of the sample. Re-entry support must therefore address practical as well as policy-related obstacles.

Table 10. Main reason for not returning to school (reported n = 30; denominator requires verification.)

Reason	Frequency	Percent
Lack of money	1	3.3
Caring for the baby	13	43.3
Lack of support from family	11	36.7
Fear of discrimination	5	16.7
Total	30	100.0

The supplied frequencies total 30, although only 13 respondents reported not returning in Table 9. If Table 10 was intended to describe only those 13 non-returners, its denominator and percentages are inconsistent. The values are reproduced exactly as supplied, but the author must check the original questionnaire/SPSS output and recalculate the table using the valid subgroup denominator before publication. The narrative must not present these percentages as percentages of non-returners until verified.

Table 11. Reported effect of pregnancy on academic performance. (n = 30)

Response	Frequency	Percent
Performance improved	6	20.0
Performance remained the same	10	33.3
Performance became worse	14	46.7
Total	30	100.0

Fourteen respondents (46.7%) reported worse academic performance, ten (33.3%) no change and six (20.0%) improved performance. The largest group reported a decline. The result is self-reported and does not substitute for examination records or a before-and-after academic comparison.

Table 12. Difficulty concentrating because of pregnancy or childcare responsibilities. (n = 30)

Response	Frequency	Percent
Yes	15	50.0
No	15	50.0
Total	30	100.0

Fifteen respondents (50.0%) reported difficulty concentrating, while 15 (50.0%) did not. This suggests that concentration challenges were common but not universal. The table combines pregnancy and childcare responsibilities, so it cannot isolate the contribution of either factor.

Table 13. Missed tests or examinations because of pregnancy or childcare responsibilities. (n = 30)

Response	Frequency	Percent
Yes	13	43.3
No	12	40.0
Sometimes	5	16.7
Total	30	100.0

Thirteen respondents (43.3%) reported missing tests or examinations, 12 (40.0%) had not missed them and five (16.7%) sometimes missed them. Missed assessments may affect progression and confidence. Schools can consider reasonable catch-up and assessment arrangements consistent with school policy.

6.2 Discussion of Key Findings

The reported attendance findings indicate that interruption to schooling was a prominent experience in this sample. Eighty per cent of respondents said they had stopped attending temporarily or permanently because of pregnancy. The reported reasons included health concerns, pregnancy-related responsibilities, financial constraints and fear of ridicule. The latter was the most frequently selected reason for missing school. This points to the importance of school climate: even where formal rules permit continued attendance, teasing, shame and discriminatory treatment may discourage a learner from remaining in class. UNESCO's evidence review recommends supportive school environments, protection from exclusion and violence, and effective continuation or re-entry arrangements for pregnant and parenting learners (UNESCO, 2017).

The academic-performance results show that 46.7% reported worse performance and 50.0% reported difficulty concentrating. These findings are consistent with the possibility that missed lessons, reduced study time, fatigue, stress and childcare demands can make learning more difficult. However, the present data do not establish which mechanism affected each respondent, and no objective examination results were supplied. The findings should therefore be described as respondents' reported experiences rather than measured causal effects.

The school-continuation results show that 43.3% were classified as having dropped out and 43.3% reported not returning after childbirth. At the same time, 56.7% reported returning to school. This is important because pregnancy does not make educational continuation impossible. Research in South Africa has documented varied schooling trajectories after pregnancy, with some young women continuing to accumulate schooling after childbirth

(Grant & Hallman, 2008; Marteleto et al., 2008). These studies also demonstrate that outcomes differ according to prior schooling, household circumstances and support, cautioning against assuming a single pathway for all teenage mothers.

The reported reasons for not returning—especially caring for the baby and lack of family support—suggest that re-entry policies must be accompanied by practical arrangements. A right to return is less effective when a learner has no reliable childcare, transport or school materials, or when family members do not support her education. The Zambian revised School Re-Entry Policy Guidelines launched in March 2026 provide a current national policy context for strengthening support to learners affected by early and unintended pregnancy (UNESCO, 2026). Their impact will depend on awareness, consistent implementation, clear school-level procedures and coordination with families and support services.

The results also need to be interpreted alongside broader evidence that pregnancy and school dropout are connected to multiple social and educational factors. Lloyd and Mensch (2008), analysing Demographic and Health Survey data from sub-Saharan Africa, caution that marriage, childbirth and other school or family factors can contribute differently to school leaving across settings. This reinforces the need to avoid attributing every instance of low educational attainment or school dropout to pregnancy alone. The present seminar's descriptive design cannot isolate the causal contribution of pregnancy from poverty, prior school performance, family circumstances or other factors.

The theoretical perspectives help interpret these patterns. Human capital theory highlights the long-term value of allowing young mothers to continue acquiring education and skills (Becker, 1964). Ecological systems theory highlights that school continuation is shaped by interacting family, peer, school, community and policy environments (Bronfenbrenner, 1979). Together, these perspectives support a response that combines individual counselling with family engagement, school-level anti-stigma measures, practical childcare support and effective policy implementation.

6.3 Data Quality Checks and Study Limitations

Several matters require verification against the original questionnaires, coding sheet and SPSS output before the manuscript is submitted. First, Table 10 is labelled as the reasons for not returning to school, but its frequencies total 30 even though Table 9 identifies only 13 non-returners. The denominator is therefore unclear. The original figures have been retained without alteration, but the table should not be published as a subgroup analysis until the valid denominator is confirmed.

Second, Table 4 presents ‘currently in school’ and ‘returned to school after pregnancy’ as separate categories. These may overlap unless the questionnaire explicitly defined ‘currently in school’ as learners who had never interrupted schooling and ‘returned’ as learners who resumed after an interruption. Third, the target participants included teenage mothers, learners, teachers, parents and social workers, yet the manuscript does not show how many respondents belonged to each group. Some questions, such as age at first pregnancy and the experience of returning after childbirth, may not apply to all participant categories. The author should verify the questionnaire routing and denominators for each item.

Fourth, the methods state that interviews were conducted, but no interview themes, quotations or participant-category breakdown are presented. Either add verified qualitative themes from interview notes or revise the methods to describe only the methods actually used. Fifth, the location and dates of fieldwork, recruitment process, ethics approval/permissions and instrument details are not specified. These omissions should be addressed from the original research records, not guessed.

The sample size of 30 and purposive sampling limit generalisability. The results describe the selected participants and cannot be assumed to represent all girls or teenage mothers in Zambia. The cross-sectional descriptive information does not establish causation. Some outcomes are self-reported, and no school attendance registers, examination scores or longitudinal follow-up data were provided. These limitations should be stated openly.

7. CONCLUSION

The seminar examined the reported effects of teenage pregnancy on girls’ education. Within the sample of 30 respondents, the findings indicate that pregnancy was commonly associated with interruption to school attendance, and that respondents reported challenges involving stigma, health, financial resources and pregnancy-related responsibilities. A substantial proportion reported stopping school temporarily or permanently. More than half reported returning after childbirth, demonstrating that educational continuation is possible, although a notable proportion did not return. Respondents also reported poorer academic performance, difficulty concentrating and missed assessments.

The findings should be interpreted cautiously because the study used a small purposive sample and because some respondent categories and table denominators require verification. In particular, Table 10 must be checked against the original data before publication. The study does not establish that pregnancy alone caused every reported educational outcome.

Nevertheless, the reported experiences underline the importance of ensuring that pregnancy or early motherhood does not become a permanent barrier to education.

7.1 Recommendations

1. Strengthen implementation of Zambia's School Re-Entry Policy Guidelines by ensuring that school administrators, teachers, learners and parents understand the procedures and responsibilities involved.

2. Provide confidential guidance and counselling for pregnant learners and teenage mothers, including referrals to appropriate health and social services where necessary.

3. Establish safe, non-discriminatory school environments by preventing bullying, ridicule, exclusion and stigmatising treatment.

4. Encourage parents and guardians to support continued education through emotional encouragement, help with childcare and assistance with essential school requirements where possible.

5. Provide academic catch-up support for learners who have missed lessons or assessments, including remedial teaching, guidance on missed work and fair arrangements consistent with school policy.

6. Strengthen coordination among schools, families, health workers, social workers and community organisations so that educational, psychosocial and practical support is connected.

7. Promote age-appropriate, evidence-based comprehensive sexuality education and access to adolescent-friendly health information and services, consistent with national law and policy.

8. Future studies should use clearly defined participant groups, verified denominators, transparent sampling procedures and, where feasible, larger samples and follow-up data to examine school re-entry and educational progression.

8. ACKNOWLEDGEMENTS

The authors acknowledges the published studies and institutional materials cited in this aiticle.

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