National Adolescent Fertility Study

TECHNICAL REPORT

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FOREWORD

Adolescent pregnancy remains a major challenge and contributor to maternal and child mortality, and to the vicious cycle of ill-health and poverty. Sub-Saharan Africa (SSA) has the world's highest level of adolescent pregnancy estimated at 101 births per 1,000 women aged 15-19 years. In Zimbabwe, the adolescent fertility rate for women aged 15-19 years was 115 births per 1,000 women of the same age in 2015. Although fertility rates among women aged 20 years and above in Zimbabwe have fallen over the last two decades, adolescent pregnancy is on the rise despite Zimbabwe having one of the highest contraceptive prevalence rates in sub-Saharan Africa.

According to the National Population Census 2012, adolescents aged 10-19 years constitute 24% of the total population in Zimbabwe. These young people face a myriad of challenges related to their development. While much of the literature centres on the important health effects of adolescent pregnancy, less was known about other kinds of consequences incurred by adolescent pregnancy in Zimbabwe. The wide-ranging consequences associated with adolescent pregnancy, the fact that little is known about adolescent pregnancy among girls below the age of 15, existing studies which were on a small scale and fragmented and the poorly understood factors behind rising adolescent pregnancy rates in an apparently enabling environment for contraceptive use, all pointed to the need to further investigate adolescent pregnancy prevalence in Zimbabwe, along with the contributory factors and consequences.

At the 1994 International Conference on Population and Development (ICPD), governments agreed on the need to "promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies" (ICPD Program of Action 7.46). Earlier actions on reducing adolescent fertility had targeted the girls as the problem and aimed at changing their behaviour as the solution. Such interventions failed to reduce adolescent pregnancy because they did not address the root causes of the problem, i.e. the socio-economic, cultural norms and values, legal and other factors that drive adolescent pregnancy. Another shortcoming of these actions is that they failed to address the "role of men and boys in perpetuating and preventing adolescent pregnancy". The Ministry of Health and Child Care, Family Health Department in collaboration with Zimbabwe National Family Planning Council (ZNFPC) and United Nations Population Fund (UNFPA) commissioned the National Adolescent Fertility Study in 2015 to better understand why adolescent fertility was increasing despite the Government efforts to reduce it. In order to develop robust and effective adolescent pregnancy prevention interventions, there is need to understand the national, community, peer, family and individual factors that contribute to adolescent pregnancy in Zimbabwe.

The National five year Adolescent Sexual and Reproductive Health (ASRH) Strategic Plan came to an end in 2015, and, therefore, the results of this study will be useful in informing the development of the 2016-2020 ASRH strategic plan and developing an evidence based multi-stakeholder national adolescent pregnancy prevention program at various levels. I therefore urge all stakeholders involved in developing and implementing ASRH programs to make use of this landmark report in developing evidence based programs so that we can halt and begin to reverse the adolescent fertility rate and its consequences.

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MINISTER OF HEALTH AND CHILD CARE




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We convey special thanks to the key stakeholders in all the ten provinces for their support and co-operation during fieldwork. Our profound gratitude is extended to all the adolescents, community members and key informants who participated in this study by providing us with valuable information for a better understanding of adolescent pregnancy in the country. Great appreciation is conveyed to all the team leaders, enumerators and drivers who tirelessly collected the data.

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LIST OF ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
CPR	Contraceptive Prevalence Rate
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IT	Information Technology
KII	Key Informant Interviews
LSCF	Large Scale Commercial Farms
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey (MICS)
MIMS	Multiple Indicator Monitoring Survey
MoHCC	Ministry of Health and Child Care
MoPSE	Ministry of Primary and Secondary Education
NFE	Non-Formal Education
PDA	Personal Data Assistance
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SSCF	Small Scale Commercial Farms
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZYC	Zimbabwe Youth Council
ZNFPC	Zimbabwe National Family Planning Council
ZDHS	Zimbabwe Demographic and Health Survey




EXECUTIVE SUMMARY

Introduction

The National Study on Adolescent Fertility was conducted to have a better understanding of adolescent pregnancy, which is on the increase. The objectives of the study were to: (i) assess the level of adolescent pregnancies in Zimbabwe; (ii) assess the factors significantly contributing towards adolescent pregnancy in Zimbabwe; (iii) establish the consequences of adolescent pregnancy; and (iv) to provide recommendations for future programming on reducing adolescent fertility in Zimbabwe.

Methodology

The study was a cross-sectional survey, involving a triangulation of data sources, i.e. both quantitative and qualitative data collection including a desk review. The study was conducted among 7,656 female adolescents aged 10-19 years in all the ten provinces. The methods of data collection included the desk review, the survey, focus group discussions (FGDs) and key informant interviews (KIIs). Interviewer-administered questionnaires were used to collect data, using tablets for data entry. FGD and KII guides were used to collect qualitative data. Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) and qualitative data using NVIVO.

Key Results

Adolescent Pregnancy Prevalence

The study revealed that 9% of the adolescents aged 10-19 years had ever been pregnant. When broken down by age group, 17% of the adolescents aged 15-19 years and 0.2% among the 10-14 years-olds had experienced pregnancy.

Factors Contributing to Adolescent Pregnancy

Individual Level

Factors significantly associated with adolescent pregnancy at individual level were age, marital status, contraceptive use, self-efficacy, knowledge on pregnancy and attitudes towards adolescent pregnancy and condoms. Adolescent pregnancy increased with age, from 2% among the 15 year olds to 42% among those aged 19 years. The married adolescents were highly likely to have been pregnant compared to the never married. Adolescents who reported no confidence in refusing unwanted sex were more likely to be at risk of pregnancy compared those with confidence and those who used contraceptives during their first sexual encounter were less likely to be at risk of pregnancy compared to those who did not use. Adolescents with no comprehensive knowledge on pregnancy and those who were supporting adolescents getting pregnant were at higher risk of pregnancy.

Inter-personal Level

Adolescents from the second, middle and fourth wealth quintile were more likely to get pregnant compared to those from the highest wealth quintile. Orphans were more likely to be at risk of pregnancy compared to non-orphans, with double orphans having the greatest risk. Adolescents who received pressure from relatives to get pregnant were more likely to get pregnant compared to those who did not receive pressure. Friends and sisters had an indirect influence as adolescents who had friends or sisters who got pregnant before the age of 20 years were more likely to get pregnant compared to those who did not have friends/sisters who became pregnant.

Organisational Level

Adolescents aged 15-19 years in rural areas were more likely to be at risk of pregnancy compared to their urban




counterparts. Prevalence of adolescent pregnancy was highest in Mashonaland Central lowest in Harare. After controlling for other factors, adolescents residing in Matabeleland North and Matabeleland South had the greatest risk of adolescent pregnancy. Adolescents of the Tonga ethnic group were more likely to get pregnant. Adolescents belonging to the Apostolic sect church were more likely to get pregnant compared to those who belonged to the African Traditional, with those attending church rarely at higher risk. Adolescents who never read a newspaper were more likely to be at risk of pregnancy compared to those who read. Adolescents who watched TV were less likely to become pregnant compared to those that did not watch while those who ever used the Internet were more likely to get pregnant compared to those who never used. Access to the media was found to be the key factor as those who did not own a radio or TV had the greatest risk. Adolescents who were subjected to sexual abuse by being touched in a way they felt uncomfortable were at higher risk of pregnancy compared to those that were not touched.

National Level

Zimbabwe has formulated policies and laws related to adolescent sexual and reproductive health. Some of these include the Marriage Act, the School's Re-entry Policy, National Non-Formal Education (NFE) and the Sexual Offences Act. The School's Re-entry Policy allows pregnant school girls to return to school after delivery but to a different school. As a result the school she will have to go to may be further from where she lives and thus making it difficult for a nursing mother to go back into class. Stigmatization of single mothers is also another reason why adolescent mothers find it difficult to go back to school. The NFE Policy also targets adolescent mothers who are not able to go back into the formal education system. The Age of Consent in Zimbabwe, which is 16 years, protects the girl child from sexual abuse. However, most cases of rape go unreported. Despite the policies and laws, adolescent pregnancy continues to be on the increase. There is also lack of harmonisation of policies as the age of marriage is 18 years while age of consent is 16 years. The policies are not effective due to lack of coordination of ministries, lack of political commitment, lack financial resources to implement and lack of effective enforcement to offenders.

Consequences of Adolescent Pregnancy

The main consequence of adolescent pregnancy experienced by adolescents aged 15-19 years who got pregnant was dropping out of school. Other consequences experienced include being chased away from home, abandonment by the man responsible for the pregnancy and abandoned by friends. More than a tenth of the adolescents reported that their first pregnancy did not end in a live birth (still birth or miscarriage/abortion).

Conclusions

The study's findings reveal that adolescent pregnancy is a national health and social problem. Although the adolescent pregnancy rate among 15-19 years has been found to be lower than the ones reported by ZIMSTAT, adolescent pregnancy has been reported to be a problem. The factors associated with pregnancy at different levels include, among others, age, ethnicity, marital status, self-efficacy, alcohol/drug abuse, knowledge of pregnancy, attitudes of adolescent towards pregnancy and condoms, orphanhood, religion, religiosity, peer pressure, poverty, socio-cultural practices, sexual abuse, social media and the Internet. The causes of adolescent pregnancy identified will help the Government and other organisations working with adolescents to understand why adolescent fertility rate is increasing and help to identify effective interventions to reduce adolescent pregnancy. This calls for interventions that are informed by the research findings, targeting the identified hotspots and the vulnerable groups of adolescents. Consequences of adolescent pregnancy have also been highlighted and these include dropping out of school, chased away from home, abandoned by the man responsible for the pregnancy, abandonment by friends, stress, low self-esteem and suicide. However, it was noted that some of




the parents and guardians accepted the situation. Education programmes that target the youth should address these negative outcomes so that they are able to make informed decisions regarding sexual relationships and to avoid pregnancy. Given the causes and consequences of adolescent pregnancy, the government should enforce the laws and legislations that are in place in order to protect the girl child against pregnancy. The effectiveness of some of the policies is hampered by limited financial resources, lack of law enforcement and lack of political commitment.

Recommendations

Based on the key findings from this national research, the following recommendations to reduce adolescent pregnancy were made:

Individual Level

- Strengthen female adolescent empowerment through life skills initiatives and revitalization of various female sensitive strategies and programmes
  - *These interventions should take a psychosocial approach to building self- efficacy, confidence and deal with stigmatization among female adolescents*
  - *Promote adolescent engagement and leadership on ASRHR issues*

- Strengthening Adolescent Sexual and Reproductive Health and Rights (ASRHR) in schools and out of schools
  - *Improve access to Life Skills / Comprehensive Sexuality Education by adolescents in and out of school*

- Address socio-cultural and religious norms and community values that undermine ASRHR and perpetuate adolescent pregnancy in communities
  - *Promote community dialogue on adolescent fertility, and harmful socio-cultural and religious beliefs and practices*
  - *Religious and traditional leaders' dialogue and engagement*
  - *Social mobilization and advocacy*

Community Level

- Social mobilization and advocacy on socio-cultural and religious issues contributing to adolescent pregnancy
  - *Foster greater community dialogue and engagement, and mobilise local traditional and religious leaders to address socio-cultural and religious drivers of adolescent fertility*
  - *Encourage parent to child communication on sexuality and sexual and reproductive health issues*

- Improve adolescents' knowledge on the laws, policies and constitutional rights of adolescents
- Targeted demand generation interventions / activities for uptake of adolescent sexual reproductive health and maternal, new-born child health (MNCH) services
- Expand availability and access to quality, safe, adolescent responsive and friendly SRH and MNCH services at sub-national level

Policy Level

- Strengthen a multi-sectoral approach, strategies and interventions that tackle drivers of adolescent pregnancy and child protection violations
  - *Improve educational opportunities for female adolescents to stay longer in school and pursue tertiary education as well as re-examine the school re-entry and non-formal education approaches to facilitate*




continued education for female adolescents
- *Promote social and community dialogue around harmful socio-cultural and religious practices, and mobilize communities to act against these practices*

- Re-alignment of policies and legislation by removing conflicting prescriptions as well as address social dis-articulation of legislation
  - *Expedite legal reviews to ensure harmonization with the current amended Constitution e.g. the Child Marriages Act and the Legal Age of Consent which require urgent harmonization. At present a girl can consent to sex at the age of 16 years but cannot be married until she attains 18 years of age despite being pregnant*

- Strengthen law enforcement and legal compliance mechanisms as well as improve child protection services in the country
  - *Given the huge problem of child sexual abuse (54% of girls age 10-14 years reported to have been forced to have sex/raped), there is need for stricter enforcement of legislative / legal instruments for child protection, including the Child Offenders Act*
  - *Alignment of legislation with constitutional provision, and legal review on penalties associated with child rape and abuse to ensure maximum deterrence through extremely punitive*

- Strengthen investment in Adolescent Sexual and Reproductive Health & Rights (ASRHR), education and child protection services

National Level

- Improve educational, socio-economic and recreational opportunities for adolescents in rural areas.
  - *Strengthen youth empowerment investments in rural areas*
  - *Foster strong linkage*s between ASRHR and youth socio-economic empowerment programmes

- Hotspot mapping of adolescent pregnancy at sub-national level accompanied by targeted interventions to address drivers of adolescent pregnancies
  - *Demand generation interventions / activities for uptake of adolescent sexual reproductive health and rights (ASRHR) services*
  - *Expand availability and access to quality, safe, adolescent responsive and friendly SRH and MNCH services at sub-national level*

- There is need for comprehensive, integrated and coordinated multi-sectoral approach to ASRHR, education and adolescent empowerment.
  - *Strengthen multi-sectoral coordination of ASRHR and youth empowerment.*
  - *Address fragmented laws and policies through harmonisation of legal instruments*
  - *Improve ASRHR s*trategy implementation and resourcing

- Strengthen law enforcement, legal compliance mechanisms and child protection services in the country
  - *Effective resourcing of child protection and law enforcement services*
  - *Advocacy and legal reviews on penalties associated with child rape and abuse to ensure maximum deterrence through extremely punitive sentences.*
  - *Empower communities to respect constitutional rights of children and adolescents, and have a zero tolerance of child protectio*n violations as well as report these violations.




- Scale-up provision of targeted social cash transfers for adolescents in poor households to enable vulnerable adolescent girls to stay in school longer and pursue secondary and tertiary education.
- Strengthen implementation of National Action Plan on Orphans and Vulnerable Children and Child Protection Services at sub-national levels
  - *Improve investment into social welfare/social work services in local communities to address drivers and consequences of adolescent pregnancy*
  - *Strengthen child protection* interventions

- Strengthen national dialogue and action against child marriages, including constitutional rights of young girls.
  - *Policy advocacy, review and alignment.*




1. INTRODUCTION

1.1. Background

Globally, adolescent pregnancy remains a major challenge. Adolescent pregnancy is a major contributor to maternal and child mortality, and to the vicious cycle of ill-health and poverty. About 16 million girls aged 15-19 and about 2 million girls under age 15 years give birth every year[1]. Approximately 95% of teenage pregnancies occur in low- and middle-income countries, with 36.4 million women becoming mothers before age 18[1,2]. The global average adolescent fertility rate was 50 births per 1,000 women aged 15–19 years in 2012, highest in Africa with 116 births and 122 births in low-income countries[3]. Sub-Saharan Africa (SSA) has the world's highest level of adolescent pregnancy estimated at 101 births per 1,000 women aged 15-19 years[2].

Zimbabwe has a young population with one-third being between the ages of 10-24 years. According to the National Population Census 2012, adolescents aged 10-19 years constitute 24% of the total population in Zimbabwe. These young people face a myriad of challenges related to their development. These challenges include unemployment, limited educational opportunities, gender-based violence, inter-generational relationships, child marriage, pregnancy, HIV infection and other negative reproductive health outcomes.

In Zimbabwe, the adolescent fertility rate for women aged 15-19 years was 120 births per 1,000 women aged 15-19 in 2014[4]. Although fertility rates among women aged 20 years and above in Zimbabwe have fallen over the last two decades[5], adolescent pregnancy is on the rise in this context. The Zimbabwe Demographic and Health Survey (ZDHS) and the 2014 Multiple Indicator Cluster Survey (MICS) data demonstrate this trend, showing a steady increase in adolescent fertility from 99 births per 1,000 women aged 15-19 in 2005-06 to 115 births per 1,000 women aged 15-19 in 2010 -11, and to 120 births per 1,000 women aged 15-19 in 2014.

The 2014 MICS also revealed significant rural-urban differentials in the adolescent fertility rate, showing that rural adolescent girls were twice as likely to become pregnant (143 births per 1,000 women) than their urban peers (75 births per 1,000 women). The 2010-11 ZDHS also reports this rural-urban differential, higher in rural areas (144 births per 1,000 women) than in urban areas (71 births per 1,000 women). The 2010/11 ZDHS reported the rural urban differentials based on the percentage who had begun childbearing, 16% of the women aged 15-19 in urban areas had started childbearing compared with 28% among their urban counterparts. The proportion of adolescents who had started childbearing were highest in Matabeleland North (31%), Mashonaland Central (30%) and Manicaland (27%) and lowest in Bulawayo (11%)[5]. Fertility rates were highest in Mashonaland Central (172 births per 1,000 women aged 15-19) and Matabeleland North (148 births) and lowest in Bulawayo (77 births) and Harare (78 births)[4].

Paradoxically in 2014, Zimbabwe had one of the highest contraceptive prevalence rate (67%) in sub-Saharan Africa compared to countries in West Africa (9%), Central Africa (7%), Eastern Africa (22%) and North Africa (45)[3]. Indeed, apart from a plateau period in 2010 (when the rate declined slightly to 59%), the country's contraceptive prevalence rate has risen steadily, from 27% in 1984, to 60% in 2006, and 67% in 2014[5]. Despite the high overall contraceptive prevalence rate, 62% of sexually active girls aged 15-19 years were not using any form of contraception[5]. Yet, findings from the 2010-11 ZDHS indicate that 34% of women aged 15-19 years had sexual intercourse, and 8% of never-married women in the




same age range reported having sexual intercourse 12 months preceding the survey[5].

In addition to low use of contraception, the contribution of sexual violence to sexual initiation and adolescent pregnancy is significant in Zimbabwe. The National Baseline Survey on Life Experiences of Adolescents revealed that about a third of females aged 18-24 years reported experiencing some form of sexual violence (sexual touching, attempted sex, forced sex, or pressured sex) before the age of 18[6]. Of these, 56% reported that the first incident occurred when they were 16-17 years old, compared to 27% and 17%, who indicated that they were aged 14-15 years old and less than 13 years, respectively[6]. Of those aged 13-17 who had their sexual debut in the 12 months preceding the survey, about 43% had unwanted first sexual intercourse, i.e., they were either forced, pressured, tricked, or threatened to engage in sexual intercourse[6]. Yet, it is plausible that other factors beyond low use of contraception and sexual violence underlie mounting fertility rates among adolescent girls in the country. Research shows that causes of adolescent pregnancies include poverty, peer pressure, alcohol and drug abuse, experimentation, cultural practices and norms[7,8,9,10].

Adolescent pregnancy is associated with health risks for the mother that include maternal deaths, complications during pregnancy and delivery, including operative vaginal deliveries, caesarean sections and maternal mortality[5,11]. Unsafe abortions are also experienced as the teenage girls try to end pregnancy[11]. The adverse outcomes are largely because the adolescents are not physiologically mature enough to produce babies[12]. Babies born to the adolescent mothers are at higher risk of morbidity and mortality, low birth weight, still births and pre-term births[1,13].

Several studies have shown that adolescent pregnancy is associated with a wide range of socio-economic consequences, including school expulsion, sent away from home, boyfriend rejection and curtail future job opportunities[1,7,14,15]. Adolescent mothers are also likely face stigma and emotional stress as a result of the pregnancy, especially if they become single mothers[16,17].

1.2. Rationale

Data on adolescent pregnancy presented in the previous section is on adolescents aged 15-19 years, yet little is known among the adolescents aged 10-14 years. Studies on adolescent pregnancy have tended to focus on adolescents aged 15-19, yet girls below age 15 are engaging in sexual activity. Rather, the studies tend to ask questions about pregnancy below age 15 from the women 15 years and above. The existing studies on adolescent fertility are small and fragmented. Hence, they are limited in terms of providing information necessary for developing a national teenage pregnancy prevention program. This study therefore generates information that informs programming on a national scale. Despite the existence of policies on child marriage and age of consent, a gap exists in the implementation of the policies.

Despite the wide-ranging consequences associated with adolescent pregnancy, little is known about adolescent pregnancy among girls below the age of 15. Existing studies are on a small scale and fragmented. Furthermore, factors behind rising adolescent pregnancy rates in an apparently enabling environment for contraceptive use are poorly understood, and hence the need to further investigate adolescent pregnancy prevalence, contributing factors and consequences of adolescence pregnancy in Zimbabwe. In order to develop robust and effective adolescent pregnancy prevention interventions, there is need to understand the national, community, peer, family and individual factors that contribute




to adolescent pregnancy in Zimbabwe. Therefore, a study was conducted to understand why adolescent fertility is increasing despite the Government efforts to reduce adolescent fertility. The National five year Adolescent Sexual and Reproductive Health (ASRH) Strategic Plan came to an end in 2015. The results of this study are useful in informing the development of the 2016-2020 ASRH strategic plan.

While much of the literature centres on the important health effects of adolescent pregnancy, less is known about other kinds of consequences associated with adolescent pregnancy in Zimbabwe. Furthermore, a comprehensive and nuanced understanding of factors contributing to adolescent pregnancy patterns in the country is lacking. At the 1994 International Conference on Population and Development (ICPD), governments agreed on the need to "promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies" (ICPD Program of Action 7.46). Earlier actions on reducing adolescent fertility had targeted the girls as the problem and aimed at changing their behaviour as the solution. Such interventions fail to reduce adolescent pregnancy because they do not address the root causes of the problem, i.e. the socio-economic, cultural norms and values, legal and other factors that drive adolescent pregnancy. Another shortcoming of these actions is that they fail to address the "role of men and boys in perpetuating and preventing adolescent pregnancy"[3].

Given the empirical evidence of adolescent pregnancy, increase in adolescent fertility and the associated causes and consequences, very few studies have been conducted among adolescents aged 10-14 years. This study was conducted to determine the extent of adolescent pregnancy and its associated causes and consequences of adolescent pregnancy among the 10-19 year adolescents.

1.3. Objectives of the Study

1.3.1. Overall Objectives of the Study

The overall objective of the study was to strengthen the evidence base on adolescent pregnancy in Zimbabwe to inform policy and programs.

1.3.2. Specific Objectives of the Study

a. To assess the level of adolescent pregnancies in Zimbabwe.
b. To assess the factors significantly contributing towards adolescent pregnancy in Zimbabwe.
c. To establish the consequences of adolescent pregnancy.
d. To provide recommendations for future programming on reducing adolescent fertility in Zimbabwe.

1.4. Scope of the Study

a. Assess the individual, interpersonal, organisational, community and public policy factors that shape and prepare young people for adulthood, highlighting positive and negative attributes.
b. Assess the consequences of adolescent pregnancy at individual, interpersonal, organisational, community and national levels.




2. LITERATURE REVIEW

2.1. Global Situation of Adolescent Pregnancy

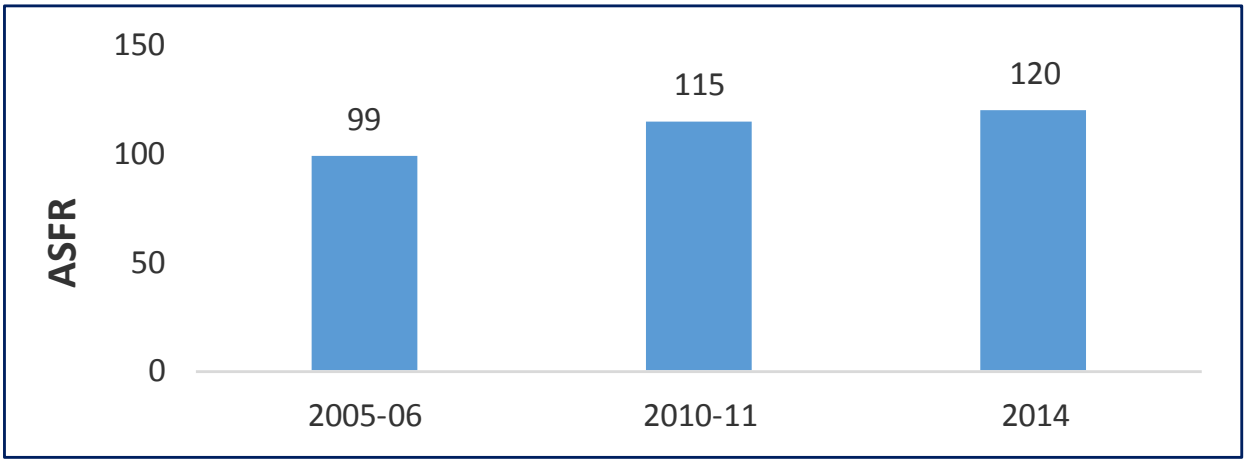
The World Health Organisation (WHO) reports that 16 million girls aged 15-19 and about 2 million girls under age 15 years give birth every year, and that 11% of all the births were among women aged 15- 19 years[1]. Approximately 95% of teenage pregnancies occur in low- and middle-income countries, with 36.4 million women becoming mothers before age 18[1,13]. The global average adolescent fertility rate was 50 births per 1,000 women aged 15–19 years in 2012, highest in Africa with 116 births and 122 births in low-income countries[3]. Sub-Saharan Africa (SSA) has the world's highest level of adolescent pregnancy estimated at 101 births per 1,000 women aged 15-19 years[3]. Adolescent pregnancy account for more than half of all the births in SSA region (ibid). Estimates from the UN Population Division indicate that adolescent fertility declined from 134 live births per 1,000 women aged 15-19 years in 1995-2000 to 115 in 2005-2010 and has continued to decline to 101 births per 1,000 women aged 15-19 years[3].

Evidence from the various DHS and MICS since 2000 on the percentage of women aged 20-24 who had a live birth before age 18 shows that almost one in five women aged 20-24 (19%) had a live birth and 3% had the live birth by age 15[3]. The proportion of women aged 20-24 who had a live birth before age 18 varies by regions, with the highest rates observed in West and Central Africa (28%) and Eastern and Southern Africa (25%) while Eastern Europe and Central Asia have the least (4%)[3]. Latin America and the Caribbean have adolescent fertility rate of 18%, which is almost close to the global estimate[3]. The top 10 countries with women aged 20-24 who had a live birth before age 18 are all found in sub-Saharan Africa, with Niger having the highest (51%), followed by Chad (28%) and Mali (26%)[3].

2.2. Adolescent Pregnancy in Zimbabwe

Adolescent fertility in Zimbabwe is currently estimated at 120 births per 1,000 women aged 15-19, increasing from 99 births per 1,000 women aged 15-19 in 2005/06[4,5]. See Figure 1.1.

Figure 2.1: Age Specific Fertility Rates, Women Age 15-19 Years, 2005/6-2014



Almost a quarter of women aged 15-19 years (24%) have started childbearing, i.e. have had a live birth or were pregnant with first child, increasing from 21% in 1999[4]. Rural women aged 19-15 are more likely to become pregnant (143 births per 1,000 women aged 15-19) compared to their urban counterparts (75 births)[4]. Also, the percentage of women aged 15-19 who had started childbearing




is twice higher in rural areas (28.7%) than in urban areas (7.3%)[4]. Teenage pregnancy was reported as a serious problem among the teenage girls aged 18-19 years and relatively serious among girls aged 15-17 years in Hurungwe District in Zimbabwe[7]. The overall teenage pregnancy rate among girls aged 12-19 was reported to be 9%, with 42% and 7% among girls aged 18-19 and 15-17 years, respectively[7]. The authors also expressed concern over the pregnancy rate of 1.1% among girls aged 12-14 years as it was indicative of abuse of girls in this age group.

Despite the availability of an adolescent sexual and reproductive health (ASRH) strategy which provides a basis for Government and stakeholder interventions to reduce teenage pregnancy, such as youth-friendly corners/centres, ASRH community committees, the school's ASRH education program, awareness campaigns, campaign for female education (Camfed), and campaigns against child marriages, adolescent pregnancy is increasing. There is need to understand the factors contributing to adolescent pregnancy. Given the intensity of efforts and commitment aimed at reducing adolescent pregnancy on one hand and the paradoxical increase in prevalence of adolescent pregnancy on the other, there is need to understand the circumstances and factors contributing to this unexpected trend. Several studies have been conducted on the determinants of adolescent pregnancies internationally, regionally and Zimbabwe, in particular. Some of the existing literature is examined here to explore what is known and gaps that exist in the understanding of the social, economic, political, psychological and environmental factors associated with adolescent pregnancy.

2.3. Factors Contributing to Adolescent Pregnancy

The factors contributing to adolescent pregnancy are presented according to the five levels of the Ecological Model, i.e. at individual, inter-personal, community, organizational and national levels.

2.3.1. Individual Level

Factors contributing to adolescent pregnancy at individual level include age, age at first sex, educational attainment, marriage, poverty, lack of information on sexual and reproductive health (SRH) issues, living arrangements and sexual abuse, are associated with adolescent pregnancy.

Age at first sex is an indicator of exposure to the risk of pregnancy during adolescence. Studies have indicated that sexual activity is more common and initiated at early years of adolescence which lead to high pregnancy. In Malawi, 12% of women aged 15-19 had first intercourse by age 15[18]. In Zambia, 12% of adolescent females 15-19 had first intercourse by the age of 15[19]. The risk of early pregnancy is worsened by early menarche. The earlier the occurrence of menarche, the earlier the biological possibility of conceiving. In Dar-es-Salaam, Tanzania, the age at menarche was between 13 to 15 years, and was associated with increased sexual activity, which put teenagers at risk of unwanted pregnancies[20]. In the Southern region of Swaziland, the average age of menarche among teenage mothers was 11 years, and their first sexual intercourse was reported to occur between the ages of 11 and 14[21] Due to lack of knowledge, advice and emotional support, the adolescents practised unsafe sex and were not aware that they could be pregnant or at risk of contracting HIV and AIDS.

Several studies in sub-Saharan Africa have reported lack of education as one of the key factors associated with adolescent pregnancy, showing a negative association[22,23,24]. In a study of teenage




pregnancy in a rural area in Nigeria, teenage pregnancy was statistically significantly associated with primary and secondary education compared to those with beyond secondary education[23]. A negative relationship between teenage pregnancy and girls' level of education was also reported, but in this case it was those adolescents who had never been to school or those who had primary education who were more likely to be vulnerable to teenage pregnancy[24]. Similarly, studies conducted in Zimbabwe also reported a negative association between adolescent pregnancy and girls' level of education[4,5,25]. A further analysis of the 2010/11 ZDHS by UNFPA in 2014 revealed that education was one of the key factors associated with teenage pregnancy25. The 2014 MICS reported a higher adolescent pregnancy among women with primary education (43.7%) than those with secondary education (19.4%).

Most of the births to adolescents in developing countries occur within marriage or union[3]. Marriage means the start of childbearing in the context of African culture. Adolescent birth rates are highest where adolescent marriage is prevalent[3]. Adolescents who marry early are more likely to participate in arranged marriages, marry older men, have less decision making power and less communication with their husbands[28]. In low-income countries, sexual activity for girls is often initiated within the context of marriage and the frequency of sexual activity is higher in adolescents who are married or in union than in those who are not, hence the greater the likelihood of pregnancy[28]. This is supported by the UNFPA further analysis of the 2010/11 ZDHS, where marital status emerged as one of the significant factors associated with teenage pregnancy[25]. Early marriage increases the chances of teenage pregnancy. This is against the background policies of the legal age of consent being 16 years and the legal age of majority being 18 years. Marriage can exert pressure and expectations upon adolescents, including the expectation of immediate pregnancy upon marriage. Adolescents who marry early are less likely to use contraception to delay the first pregnancy[29]. In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy. For example, in some sub-Saharan African countries and Indian sub-continent, early pregnancy is often seen as a blessing because it is proof of the young woman's fertility[30].

Poverty has always been associated with early marriage and pregnancy. Low socio-economic status was associated with adolescent pregnancy (57%) in Tanzania[23]. Teenage pregnancy can be a result of poverty because some of the adolescent women are involved in sexual relationships with older men who give them gifts such as money, clothes, and other goods in exchange of sex[31]. In addition, girls engage in sexual relationships with older men for financial and material gains, such as the "3 Cs", i.e. cellphone, cash and car[31]. In most cases, they are not able to negotiate safe sex and thus end up pregnant. Teenagers who grow up in poverty may end up in prostitution as a way of earning money. The inability of adolescents to meet personal and basic needs expose them to pre-marital sex in exchange for money and material gains, such factors are likely to predispose them to unwanted pregnancies and childbearing. A study in Malawi indicates that 66% of adolescents have accepted money in exchange for sex[32]. In Nigeria, adolescents whose parents were poor are more likely to engage in premarital sex which can lead to adolescent childbearing than adolescents whose parents were middle to high income level[33].

Similar findings were also reported in Zimbabwe. The 2014 MICS reported that women aged




15-19 in the lowest wealth quintile were more likely to have started childbearing (34.1%) than their peers in the highest wealth quintile (8.8%). In a study in Hurungwe, material need or child poverty was found to be a contributing factor to teenage pregnancy[7]. Over a third (34.8%) of teenage girls who were interviewed, reported engagement in transactional sex for monetary gain[7]. Similarly, lack of economic opportunities were cited as predisposing factors of early motherhood[34,35].

Adolescents engage in sexual activity, yet contraceptive prevalence among these young people is very low. High levels of adolescent pregnancy and childbearing in Africa are largely because of a lack of adequate information and barriers to accessing and using contraception[36]. In SSA, an estimated 35% of pregnancies among adolescents are unwanted[36]. Countries with a high level of unsatisfied demand for family planning among adolescents have generally high levels of adolescent pregnancy[37]. In 23 out of 41 countries, 18 of which were in SSA, the proportion of demand was unsatisfied with more than 50% among adolescents[37]. Unmet need for family planning among adolescents can be due to difficulties in accessing or using family planning services, social stigma, shame and fear. Adequate knowledge of contraception is often lacking among adolescents in Africa due to negative attitudes regarding sexual activity before marriage. Adolescents are not educated about contraceptive use because most African cultures believe that adolescents have to wait until marriage for them to have sex. Adolescents may lack knowledge of, or access to, conventional methods of preventing pregnancy, as they may be too embarrassed or frightened to seek such information from the parents or health facilities[31].

The 2010/11 ZDHS reports that 35% of the married women aged 15-19 years were using a modern method of contraception. A similar contraceptive prevalence rate was reported among unmarried women aged 15-19, but the cases were unweighted. Insufficient knowledge regarding contraceptives and pregnancy prevention options among adolescent women contribute to adolescent pregnancy[35]. Lack of knowledge of a specific contraceptive method, i.e. emergency contraceptives, were singled out[38]. Lack of knowledge of contraceptives among young women is largely due to negative attitudes regarding sexual activity before marriage[38]. Other examples of insufficient knowledge on contraceptives include the negative social norms found within societies and parents' fear of their children engaging in sexual activity when given information on contraception[32]. Contraceptive side-effects were also cited as a contributing factor to teenage pregnancy[38]. Nowadays, young people go to parties where alcohol and drug abuse are the norm. In a study of adolescent pregnancy and childbearing among women age 15-24 years, alcohol and drug abuse were cited as factors contributing to adolescent pregnancy and childbearing[15].

2.3.2. Inter Personal Level

Adolescents are most likely to get pressure from the family and their peers. The family may either promote early pregnancy or oppose girls' accessing sexuality education and other information about pregnancy prevention[3]. Lack of access to sex education predisposes adolescent females to pregnancies[24]. The influence of the family has declined; urbanisation and migration have become more common. Culturally, aunts have played the role of educating girls on sexuality. However, with increased modernization, they no longer play their role, and parents are expected to educate their children on such matters. However, most mothers do not feel




comfortable enough to talk to their daughters about sex. Lack of sex education and parental guidance, predispose young women to adolescent pregnancy[7,40]. Few interventions have been developed and tested to improve knowledge, attitudes and ultimately practices in this group.

Adolescent girls often face peer pressure from their boyfriends and social networks to engage in sexual intercourse and most of the girls become pregnant as they are not fully aware of the consequences of sexual intercourse and use of contraception[7,15,40]. UNAIDS conducted a web-based poll in June 2011 on "Factors causing the increase in number of teenage pregnancies". The results indicated that most of the participants felt that peer pressure to have sexual intercourse at a young age was a major cause of adolescent pregnancies. Findings from a study conducted in Hurungwe, a rural district in Zimbabwe, showed that 46% of teenage girls interviewed reported being pressured by their partners and peers to engage in early sexual activity[7]. Almost a quarter of the participants (23%) felt that peer pressure to have sexual intercourse at a young age was a major cause of adolescent pregnancies[40]. In a qualitative study of teenage mothers and fathers, it emerged that several female participants had been forced into sexual intercourse by their boyfriends or relatives[41].

Children not staying with both parents have been reported in several studies to be vulnerable to adolescent pregnancy[35]. Other studies have found that father absence is associated with adolescent pregnancy[39]. Children staying on their own and orphans were more likely to be at risk of adolescent pregnancy because of social economic reasons[35].

2.3.3. Community Level

Adolescent pregnancy also results from coercion and/or sexual violence, particularly by older men[28,35]. This is consistent with the UNFPA's further analysis of the 2010/11 ZDHS which found that experience of sexual violence was significantly associated with teenage pregnancy. Younger girls are at risk of sexual violence because they are perceived to be HIV free and are the preferred sexual partners by older men, placing them at a greater risk of pregnancy[28]. The situation is further compounded by the gender disparities between men and women at both societal and personal levels, which results in asymmetrical power relations in favor of men[35]. This imbalance pre-determines sexual abuse, coercion and pressure from partners, consequently leading to adolescent pregnancies.

The community may oppose girls' access of comprehensive education and other information about pregnancy prevention[3]. The subject of adolescent sexuality remains a taboo in most societies. Cultural norms in most African societies impose barriers for discussing about sexual matters. Even mentioning the word 'sex' can imply the sexual experience and promiscuity that may damage reputation. Hence, many adolescent girls ignore sexual issues discussions in order to preserve their reputation[44]. Teenagers, especially girls, who experience body changes, find it difficult to discuss these changes with their parents, hence become involved in pre-marital sex[45].

Modern technology was cited as contributing greatly to influencing the youth in "experimenting" what they would have seen, learnt, watched or shared with peers[35]. The authors explained that this kind of influence was because adolescents easily access the internet and can view pornography on their mobile phones, computers and television.




2.3.4. Organisational Level

Adolescent fertility in SSA countries is higher in the rural areas than in the urban areas, which is influenced by limited knowledge and access to contraceptive, level of education and socio-economic factors. In Zimbabwe, several studies have examined fertility trends in the country and the socio-economic and environmental factors associated with adolescent pregnancy. The 2014 MICS revealed that rural women are more likely to have started childbearing (28.7%) than their urban counterparts (14.2%). The 2010/11 ZDHS also shows adolescent pregnancy being higher in rural areas (144 births per 1000 women aged 15-19) compared to 71 births in urban areas. Today, society demands more of young people than ever before. With openness of modern culture, greater autonomy is an expectation of adolescence. An increase in urbanization and industrialization means that economic independence is achieved through more education and training. The urban areas lack the extended family role and parents no longer play the important role of educating their teenagers in sex-related matters. In Africa and Zimbabwe in particular, literature on parent-adolescent communication is scarce. However, few studies conducted in Africa found that adolescents view the discussions as one-sided, with parents/guardians telling what to do or not do, rather than listening to their needs[26]. In the Zimbabwean culture, traditionally, it was the role of parents/guardians to educate adolescents as they grew into puberty, however this practice has been eroded by modern practices and urbanisation[26,27]. However, contrary to this finding in a study conducted in Tanzania, 83% of the students got reproductive health education from parents/guardians and health centres[23]. In addition, housing is a notable urban problem that forces many families to share small single rooms. This deprives the adults of their privacy and sometimes exposes the children to parental sexual behaviour, which is traditionally unacceptable. Thus, the traditional social restraints of early sexual activity are being relaxed by urbanization[27].

Social institutions also contribute to adolescent pregnancy, either positively or negatively. According to the traditional Zimbabwean culture, aunts and uncles have the responsibility to educate adolescents of puberty and sexuality. Although this is no longer the case as their role has been eroded by modernization and urbanization, these aunts and uncles are always called upon at social and cultural events to advise couples prior to lobola or weddings[46]. Parents, who are now supposed to take over that role, lack knowledge to impart to their children because they were never taught themselves when they were young while others still regard it as taboo to discuss SRH issues with adolescents[46]. Studies in Tanzania revealed that parent-child communication on SRH issues was mainly in the form of warnings, threats and physical discipline[47]. Thus, there is a huge gap of communication about sexual issues between parents and their children. The 1999 National HIV and AIDS Policy guiding principle 40 calls for encouraging and supporting parents and extended family members to take an active role in educating their children about sexuality, HIV and AIDS and on the development of programmes to strengthen parents' ability to communicate with their children about sexuality and HIV and AIDS[46].

Another social/cultural norm is early marriages. Some communities and religious groups, through their social and cultural practices, promote early marriages and teenage pregnancies[46]. Girls are married off early because they are viewed as 'someone else's wealth' and even a liability to be got rid of as soon as possible. In addition, early marriages are in practice because of the social norm which deems that fathers have to pay higher dowry for older girls[48]. Some parents




also think that, if they marry their daughter earlier, then they can reduce the expenditure of food and education[48]. Religion also has an influence on contraceptive use and marriage. Marrying off girls to older men in the Apostolic church is acceptable, and it is part of the religious norms and practices[7]. In the traditional setting, abortion is sometimes condoned when a pregnant girl is deemed too young to give birth or a married woman gets pregnant again too soon after giving birth[49].

In some cultures, young girls or adolescents are influenced to fall pregnant at an early age to prove their fertility prior to marriage[8]. In Malawi, girls are taught about the importance of childbearing at an early age. This message is communicated in such a way that many adolescents do not see early childbearing as a problem[42]. The initiation ceremonies by Yao and Chewa tribes in Malawi promote early sex and early marriage. Furthermore, at the end of the first initiation ceremony, an older man is enlisted to be the first sexual partner of the adolescent to mark her womanhood[43]. As a result, this puts adolescent girl at risk of childbearing. The practice of virginity tests in Hurungwe was reported to contribute to teenage pregnancy as the "girls are forced to elope to the man whom they would have sex with to avoid the embarrassment and repercussions of being known by parents to have lost virginity"[7]. As result, they are forced to marry and start having children.

According to UN agreements and recommendations, adolescents have a right to receive accurate sexual and reproductive health information and confidential services without discrimination[50]. However, most institutions (e.g. educational and health) discourage adolescents getting information and access to ASRH services. For example, schools may not offer sexuality education and if they do, it will be limited, and thus the adolescent girl may rely on information, which is often inaccurate, from peers about sexuality, pregnancy and contraception[3].

In health institutions in Zimbabwe, service providers use their discretion to restrict adolescents' access to services and information on contraception and STI prevention[46]. Access to contraceptives among adolescents is very limited. While Zimbabwe boasts of high contraceptive use among its married population, these services are less available outside the urban setting, and, furthermore, are not readily accessible to young unmarried males and females. Access to reproductive health services, such as contraceptives is critical in avoiding unwanted pregnancies. In an analysis of the 2010/11 ZDHS, it was reported that user fees for contraceptive services imposed by urban authorities may have affected more of the urban women than their rural counterparts. The cost of services and commodities, such as contraceptives and consultation fees at health facilities, was also noted to be an inhibiting factor by pregnant teenagers and young mothers in Hurungwe[7]. Young women also face challenges in accessing contraceptives from service providers as they are at times asked reasons why they require them[38]. Access to services such as pregnancy testing at health services were poor[7]. Several studies have found low uptake of antenatal care among teenagers compared to adult mothers[48,51]. The possible reason given for the low uptake of ANC was lack of 'physical and mental maturity'[48]. Similarly, in Zimbabwe, the 2015 ZDHS shows that ANC attendance was higher among older mothers aged 35-49 years (77%) compared to mothers aged below 20 years (73%)[52].




2.3.5. National Level

Many governments are signatories to international conventions, e.g. the Convention on the Elimination of Discrimination against Women (CEDAW) and the Convention on the Rights of Child (CRC). At national level, several policies and legislations have been put in place to address the plight of adolescent girls, some of which may indirectly address adolescent pregnancy. Such legislations include the Adolescent Sexual and Reproductive Health policy, Education policy, the schools' re-entry policy, national constitutions, policies that promote girls' education, age at marriage, age of consent, age of majority etc.

Other countries have national Constitutions embedding girl child protection, e.g. the Malawi Constitution of 1994 recognises the right to education (Section 25), and in Ghana, article 25(1) of the national constitution recognizes the right to equal education. Despite the majority of the developing countries being signatories to international charters and conventions, and have laws and policies that discourage child/early marriages, pregnancies and motherhood, adolescent pregnancy rates in these countries remain high[2]. At national level, some of the policies may restrict adolescents' access to SRH information and services, including contraception, but usually face resistance at organisational and community levels[3].

In some countries, there has resistance towards the school's Re-entry Policy. The debate on school teenage pregnancy policies in SSA has been on-going. Some of the countries have revised their policies and practices for pregnant girls to return to school after delivery, a move that was aimed at making it easier for young mothers to continue with their education[54]. Such countries include Cameroon, Madagascar, Malawi, Kenya, South Africa and Namibia[54]. Most of these countries allow the adolescent mother to return to school immediately and some allow the mother to continue with schooling. Contrary to this, in Zimbabwe, a pregnant girl must drop out of school and re-apply after two years and re-enrolment is made subject to availability of space[54]. The resistance to this re-entry policy has been reported in many countries. For example, in Zambia, during the opinion poll conducted in 2001 when the country was considering adopting the re-entry policy, church, parents, teachers and schoolboys were against the readmission of pregnant girls into school[55]. In Tanzania, although the Constitution of Tanzania grants every child the right to education, yet a girl's access to education is denied when she becomes pregnant or gives birth[54]. Expulsion of pregnant girls, according to the UN Convention on the Rights of the Child (1989), is a violation of girl children's rights to education.

In Zimbabwe, national laws and policies generally uphold parental consent requirements for adolescents below the age of 18 years[46]. However, there is inconsistencies in some of the laws, e.g. age of consent, which is 16 years versus age of marriage, which has been revised to 18 years in 2016. There is need for legislators and policymakers to review the national legislation, as well as customary laws, in light of international standards[2].

2.4. Consequences of Adolescent Pregnancy

Adolescent pregnancy can have immediate and lasting consequences for a girl's heath, education and income-earning potential[3]. These consequences are discussed under this section.




2.4.1. Health Consequences

Adolescent pregnancy is a major health concern because of its association with higher morbidity and mortality for both the mother and child.

Health Risks to the Mother

Considerable health risks are confronted by adolescent girls during pregnancy and childbirth. Teenage mothers are more likely to experience adverse pregnancy outcomes[1,5]. The health risks posed by adolescent pregnancy and childbearing are well-documented, and include maternal death, illness and disability, including obstetric fistula, complications of unsafe abortion, STIs, including HIV as well as higher morbidity and mortality levels experienced by the children of adolescent mothers[1,25]. Most of the complications that adolescent mothers face during delivery stem from immaturity of the pelvic bones and of the birth canal[13]. This may be a significant factor in obstetric risk in young adolescents. Adolescents' physically immaturity makes them particularly vulnerable to prolonged, obstructed labour, which may result in obstetric fistula, especially if an emergency Caesarian is unavailable or inaccessible[3]. Evidence suggests that because of the relative immaturity of their physiological development, adolescents are more likely than older women to experience complications during delivery[56].

Complications during pregnancy and childbirth are the second major cause of death among adolescents aged 15-19 years globally[1]. Research confirms that the adolescent girl population accounts for 15% of the global burden of disease for maternal health conditions, and 13% of all maternal deaths[57]. While adolescents aged 15–19 years are twice as likely to die in childbirth as women in their twenties, those under 15 years are five times more likely to die in childbirth[3]. There are higher incidences of caesarean section, operative vaginal delivery (both vacuum and forceps extraction) and even obstetric fistulas in adolescents, compared with that of older women. This suggests an increased risk of prolonged and obstructed labour in adolescents. Hypertension, which occurs mainly among women having their first child, is most prevalent in pregnancy complication that afflicts adolescent mothers[11]. A north India study showed that the prevalence of anaemia is high among teenage mothers (46%), which occurs due to low intake of dietary iron[51]. High levels of depression among a sample of pregnant adolescents showed that 54% had depression[58]. Adolescent mothers suffer from stress and trauma when they realise that they are pregnant and the difficulty they face in deciding who to tell and what to do, as well as the negative response they receive from family and friends[16].

Complications from pregnancy and childbirth are a leading cause of death among girls aged 15-19 years. Factors contributing to maternal death and illness include physical immaturity, complications from unsafe abortion and lack of access to routine and emergency obstetric care from skilled providers[3]. Other contributing factors include poverty, malnutrition, lack of education, child marriage and the low status of girls[28.] Young adolescents aged 10-14 years are at higher risk of maternal death compared to their older counterparts[59]. The mortality among adolescents is partly caused by delayed and reduced prenatal care among adolescent women. Reasons for the delay in seeking prenatal care not seeking may be that they are not married, or still cannot believe or accept that they are pregnant, they are less familiar with health care system, and that they have fewer resources to obtain prenatal care[60].




Research has also shown that unwanted pregnancies among adolescents tend to result in unsafe abortions[28]. Unsafe abortions account for almost half of all abortions[61]. Ninety-eight per cent of the unsafe abortions take place in developing countries, where abortion is often illegal[3]. Data on abortions among 10-14 years are scarce, but available data among 15-19 show that 3 million unsafe abortions occur annually among adolescents aged 15-19, contributing to maternal deaths and to lasting health problems[1]. Another research effort echoes this finding, estimating that 14% of all unsafe abortions in developing countries are sought by adolescents aged 15–19 years, with African countries accounting for 26% of such abortions[11].

Health Risks to Infants and Children

Children born to very young mothers are at increased risk of illness and death which are due to complications during pregnancy, child birth and post-natal period[1,5]. About 1 million children born to adolescent mothers do not make it to their first birthday[3]. For those infants who survive, they are more likely to be of low birth weight and be premature than those born to women in their 20s[3]. Stillbirths and newborn deaths are 50% higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29[28].

2.4.2. Socio-Economic Consequences

Psycho-Social Consequences

Adolescent pregnancy may also have psycho-social consequences. The baby may face neglect from the adolescent mother as the young mother may not be willing or be able to give it the undivided attention it needs[62]. The young mother may also be overwhelmed by the constant needs of the child[62]. The U.S. Centres for Disease Control and Prevention notes that babies born to teens may have weaker intellectual development and lower skill set scores at kindergarten and may also have ongoing medical issues and behavioural issues[62].

Adolescent pregnancy can have negative psycho-social effects on girls, their families and communities[1]. The most published consequence is school expulsion, with regards to educational attainment[1,12,34]. Women who become mothers in their teens are more likely to curtail their education[5,14]. A study in Chile found that being a mother reduces a girl's likelihood of attending and completing high school by between 24% and 37%[63]. To address this issue, some countries have introduced the school retention policy that allows re-admission of pregnant students and teenage mothers back into the school system, but this still remains a major problem in many schools in different countries. For example, in South Africa, the Constitution and the Schools Act of 1996 state that girls who become pregnant should not be denied access to education. However, one review found that only about one in three adolescents who left school because of a pregnancy ever returned[16]. Resistance to this policy of re-entry has been reported in Zambia, where during the opinion poll conducted in 2001 when the country was considering adopting the re-entry policy, church, parents, teachers and schoolboys were against the readmission of pregnant girls into school[55]. Reasons cited against readmission include loss of discipline in schools, lowering standards of education, encouraging immorality, encouraging more girls to become pregnant, against Christian faith, sex before marriage seen a as a taboo, etc.[55,64]. As a result, expulsion of pregnant and mothering students is still prevalent in many countries.

Girls who become pregnant are also likely to suffer from stigma, rejection by parents and the




man responsible for the pregnancy. Adolescent mothers have nowhere else to go except their parents' houses, and increased visibility in the society also means increased stigma[16]. This stigma stems from the relation of teen pregnancy, contraceptive use, HIV and STIs to sexuality, thus it will forever remain bounded with morality and stigma[16]. This stigma, during or after pregnancy, can lead to depression, social exclusion, low self-esteem and poor academic performance affecting the prospects of employment in the future[16]. Early childbearing is highly stigmatized and girls report the trauma, fear, shame, and embarrassment of having to reveal an early pregnancy to family, partners and peers[12].

A pregnant unmarried adolescent might be considered an embarrassment to the clan and is either abandoned or chased away from home, and therefore left with no guaranteed means of support both for the child and for herself[34]. In Zimbabwe, where childbirth outside of marriage goes against social mores, unintended pregnancy is likely to be high among unmarried adolescent girls[65]. Boyfriends rejected teenage mothers after the teenage girls became pregnant[34]. This, coupled with the country's legal restrictions against abortion, likely leads to unsafe abortion practices among adolescents. Although reliable data on the scale of the problem are not available, pregnancy is increasingly recognized as a reason for suicide among pregnant girls. Similarly, pregnancy among unmarried girls in some cultures is reported as a ground for homicide, on the basis of maintaining family honour[13]. Teenage pregnancy has also been associated with domestic violence and family disruptions. This is because they largely feed into existing gender imbalances by rendering the young mother more economically vulnerable and reliant on male partners, thus exposing them to negative trajectories[66].

Early pregnancy increases the probability of marriage. However, in recent decades, non-marital childbearing among teenagers has lost much of its stigma and, consequently, has increased. Today, nearly 80% of fathers of children born to teen mothers do not marry the mothers, up from 15% in 1960[66]. Teenage pregnancy affects the marriage prospects of young women and teen mothers are more likely to be single parents and, if married, are more likely to experience high divorce rates[16]. The adolescent mother may also face rejection from the partner responsible for the pregnancy. Consequently, teen mothers spend more years as single parents, and are more likely to be the sole providers for their children[67].

Economic Consequences

As a result of little or no education, adolescent mothers are likely to have fewer skills and opportunities to find a job[38]. Existing empirical data from Sweden show that relative to women aged 20–24 years at their first childbirth, adolescent mothers faced increased odds of being unemployed later in life and increased odds of being unskilled blue-collar workers[12]. Due to unemployment these adolescent mothers live in poverty. About 60% of women who have their first child during adolescence are more likely to live in poverty than those who delayed childbearing until young adulthood[67]. This poverty is worsened if the teen mother is already living in squalid conditions that have poor health services, poor standards of living and also inferior housing. The teenage mother may also face financial difficulties as it is expensive to raise the child as most are not employed[62].

The inability to secure a job can also be felt at national level, in terms of economic costs to




the country of loss of annual income a young woman would have earned over her lifetime, if she had not had an early pregnancy[1]. Teenage pregnancy also represents a big problem to the society and the nation at large. In countries where child grants exist, teenage pregnancy may be a cost to the nation. For example, in the USA, teenage pregnancy is estimated to cost between $9.4 and $28 billion a year through public assistance payments, lost tax revenue and expenditure for public health care[17]. This puts a financial strain on the budget of the nation as these funds could have gone to helping the poor. As a result of the lower earning capacity of teen mothers, they are more likely than their peers to receive child welfare for a longer period, such as the child support grant in South Africa[17]. A girl who delays pregnancy is likely to stay in school and economically secure a more lucrative job or other income-earning opportunities[68]. Investments that empower girls are beneficial to the economy. The lifetime opportunity cost related to adolescent pregnancy, measured by the mother's foregone annual income over her lifetime, ranges from 1% of annual GDP in China to 30% of annual GDP in Uganda[3]. The opportunity cost is a measure of "what could have been" if only the additional investment had been made in girls[3].

2.5. Theoretical Framework

While much of the literature centres on the important health effects of adolescent pregnancy, less is known about other kinds of consequences associated with adolescent pregnancy in Zimbabwe. Furthermore, a comprehensive and nuanced understanding of the contributory factors behind adolescent pregnancy patterns in the country is lacking. At the 1994 International Conference on Population and Development (ICPD), governments agreed on the need to "promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies" (ICPD Programme of Action 7.46). Earlier actions on reducing adolescent fertility had targeted the girls as the problem and aimed at changing their behaviour as the solution. Such interventions fail to reduce adolescent pregnancy because they do not address the root causes of the problem, i.e. the socio-economic, cultural norms and values, legal and other factors that drive adolescent pregnancy. Another shortcoming of these actions is that they fail to address the "role of men and boys in perpetuating and preventing adolescent pregnancy"[3].

The proposed study will draw on an extended ecological model (See Figure 2.2) which carefully teases out the determinants of adolescent pregnancy, while also providing a framework for investigating associated consequences[3]. The model addresses drivers of adolescent pregnancy at different levels rather than just looking at the individual girl. The model focuses on five possible levels of determinants, including the individual, interpersonal, organizational, community, and national/policy levels. These determinants operate at more than one level. Driving forces at individual level include "girl's socialization and the way it shapes her beliefs about pregnancy"[3]. At interpersonal level, family members may force a girl into marriage. At organizational level, schools are included in this level and these may or may not offer sexuality education and thus may end up relying on information from peers on sexuality, pregnancy and contraception, which may be incorrect. At community level, there are the socio-cultural norms, values and attitudes which may prohibit adolescent girls' access to sexual and reproductive health (SRH) services. At national level, the model accounts for forces, such as "policies regarding adolescents' access to contraception or lack of enforcement of laws banning child marriage"[3]. The study extends the model further to examine the consequences of adolescent pregnancy at these levels.



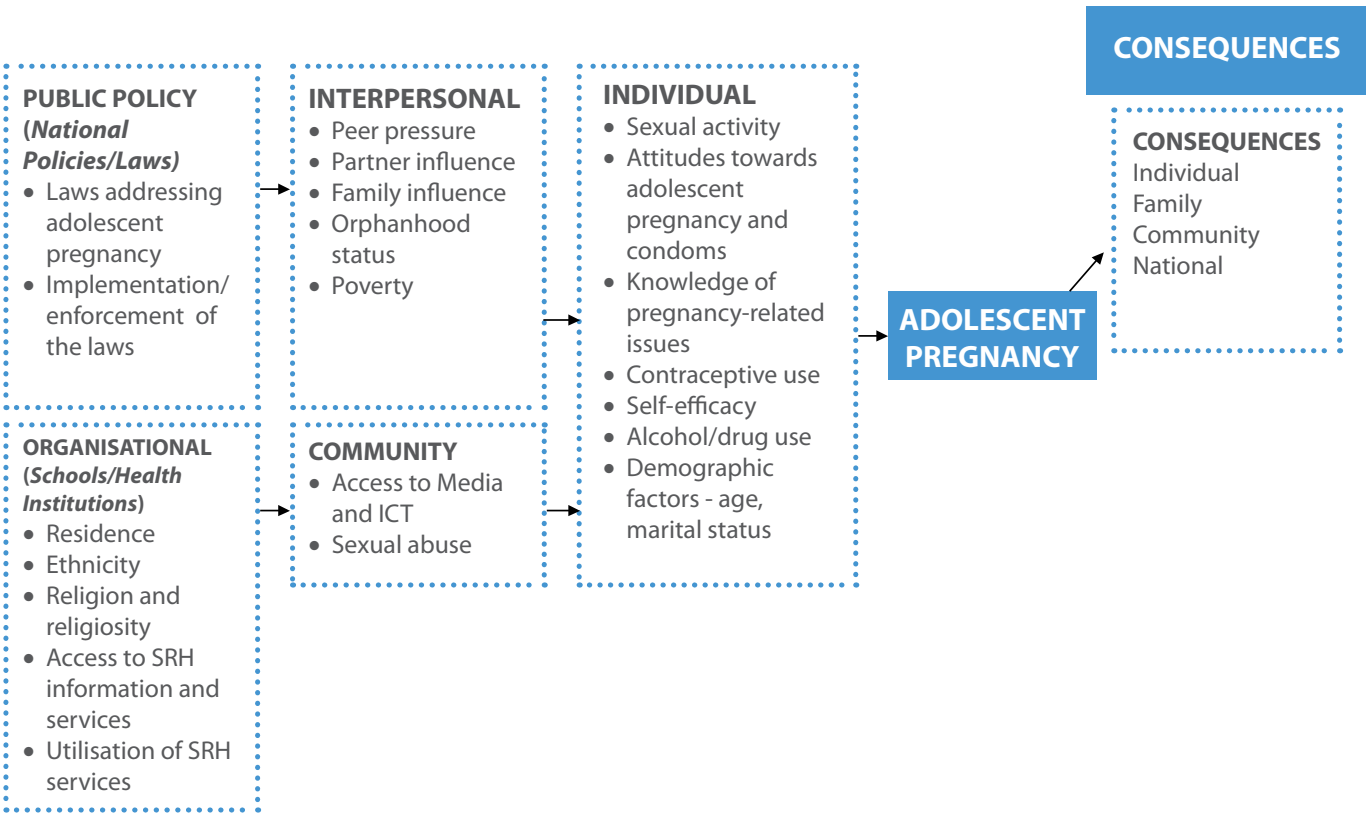

Figure 2.2: Ecological Model of Determinants of Adolescent Pregnancy

Conceptual Framework (Adapted from UNFPA, 2013)

Given the background of the Ecological Model on determinants of adolescent pregnancy, this study adapted the model to come up with the conceptual framework of the National Adolescent Pregnancy study, as it addresses all the factors from different angles driving adolescent pregnancy (Figure 2.3). The study's conceptual framework provides a guide on the indicators of determinants of adolescent pregnancy were investigated. At individual level, factors contributing to adolescent pregnancy include: knowledge about sexual and reproductive health and services; attitudes towards adolescent pregnancy; beliefs on use of sexual and reproductive health services; sexual behaviour; self-efficacy; alcohol and drug abuse; age at menarche; and demographic variables such as place of residence, religion, education, marital status and other related issues. At interpersonal level, driving forces include partner influence; parenting; family support; and poverty peers, friends and social institutions. At organizational level, focus will mainly be on schools and health institutions. At community level, factors that affect the girl include: cultural beliefs, norms, values and practices; sexual abuse/violence; and social media amongst others. Public policy level focus will include policies such as marriage law, enforcement of these laws, adolescent sexual and reproductive health framework, and political will by government to addressing challenges of adolescent pregnancy.




Figure 2.3: Conceptual Framework for Factors Contributing to Adolescent Pregnancy and Consequences






3. METHODOLOGY

3.1. Study Sites

The study was conducted in all 10 provinces of Zimbabwe, i.e., ***Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Masvingo, Matabeleland North, Matabeleland South, Midlands, Harare and Bulawayo.*** Within each province, districts were identified. The geographical locations from which the study participants were drawn within the selected districts included urban-rural residence.

3.2. Study Population

The study population was selected based on their contribution to a better adolescent pregnancy and these included:

- Female adolescents aged 10-19 years living in the urban and rural areas of Zimbabwe.
- Male adolescents aged 15-19 years living in the urban and rural areas of Zimbabwe.
- Community members: parents or guardians; political, traditional and religious leaders; traditional medical practitioners; village health workers; police; and school officials.
- ASRH service providers at community level: clinics, hospitals, youth-friendly centres, community-based organizations and non-governmental organizations (NGOs).
- Key stakeholders at national and sub-national level:
- Ministry of Health and Child Care (MoHCC)
- Zimbabwe National Family Planning Council (ZNFPC)
- United Nations Population Fund (UNFPA)
- Ministry of Primary and Secondary Education (MPSE)
- Ministry of Women Affairs, Gender and Community Development (MoWGCD)
- Ministry of Youth, Indigenisation and Economic Empowerment
- Zimbabwe Youth Council (ZYC)
- Ministry of Public Service, Labour and Social Welfare

3.3. Study Design

This was a national cross-sectional study involving both quantitative and qualitative data collection, as well as a review of existing documents. Triangulation of information sources and opinions was central to gaining full proof of findings, and also as a means for validation of study information.

3.4. Methods of Data Collection, Sampling, Recruitment and Data Collection

3.4.1. Desk Review

The purpose of a desk review was to gather contextual data to understand the factors at individual, family, community, organisational and national levels that have a bearing on adolescent fertility in Zimbabwe. The documents that were reviewed were purposively identified with the help of the MoHCC and partners supporting or implementing health programs in the country. Documents reviewed include:

- Policy documents including Adolescent Sexual and Reproductive Health Strategy, School Re-entry Policy, life skills curriculum, and laws related to ASRH (e.g. on contraception and abortion). The review of policy documents was done to further understand public policy/ national level factors contributing to adolescent pregnancy in Zimbabwe. The review




gathered information on laws and policies that relate to adolescent sexual and reproductive health and rights including age at marriage, age of consent, ongoing debates around the laws, e.g. compliance with their implementation and contradictions between the laws (legal age of majority/marriage versus legal age of consent). The policy review also focused on issues relating to adolescent pregnancy including, availability and access to services for adolescents, availability of relevant information including sexuality education, and information on the implementation of adolescent sexual and reproductive health programs.

- Studies on adolescent pregnancies or with a component of adolescent pregnancies conducted in Zimbabwe such as the ZDHS and the MICS were reviewed to examine what other studies have found out on the levels, determinants and consequences of adolescent pregnancy. The review of these studies informed the study design through identifying the strengths and weaknesses of previous studies and provided a basis for comparison of study results.

3.4.2. Survey

A survey was conducted among adolescent girls aged 10-19 years to determine the levels of adolescent pregnancy, contributing factors and consequences of adolescent pregnancy.

3.4.2.1. Sample Size

The national adolescent fertility rate was used to determine the sample size at 95% confidence level. The sample size ***expressed as the number of households*** was calculated using the following formula:

$$n = \frac{[4(r)(1-r)(deff)]}{[(0.12r)^2(pb)(AveSize)(RR)]}$$

Where:

n is the required sample size, expressed as number of households
4 is a factor to achieve the 95% level of confidence
r is the predicted or anticipated value of the indicator, expressed in the form of a proportion, i.e. the proportion of adolescents who have started childbearing (either ever been pregnant or pregnant with first child).
deff is the design effect for the indicator, estimated from a previous survey
0.12r is the margin of error to be tolerated at the 95% level of confidence, defined as 12% of *r* (relative margin of error of *r*)
pb is the proportion of the total population upon which the indicator, *r*, is based
AveSize is the average household size (number of persons per household)
RR is the predicted Response Rate




Table 3.1: Sample Size Calculation for Adolescent Pregnancy Survey

Parameter		Value	Estimate	Value 1	
Predicted value of indicator (in target/base population)	*r*	0.24	Predicted *r*	**0.24**	
Design effect	*deff*	1.2	Confidence limits (at 95% confidence)		
Relative margin of error at 95% confidence	*RME*	0.05	Upper	**0.252**	
Proportion of target/ base population in total population	*pb*	0.17	Lower	**0.228**	
Average household size	*Average Size*	4.2	Number of households (Sample size): *n*	**8870**	
Response rate	*RR*	0.96	Standard error (*se*)	**0.006**	
Cluster size (Number of households per cluster)/EA	**30**			Number of clusters/EAS	**253**
Final Calculated Sample				**Effective no. of households**	**7 590**

A sensitivity analysis with various average household size of adolescents is summarized in Table 3.2.

Table 3.2: Summary Table of the Sensitivity Analysis with various Design Effect

R	4xr	1-r	Design effect	RME	Pb	Average HH size (assuming 1 Adolescents/HH)	RR	Cluster Size	Sample size	No of EAS
0.24	0.96	0.76	1.2	0.05	0.17	4.2	0.96	30	8515	296
0.24	0.96	0.76	1.2	0.06	0.17	4.2	0.98	30	5913	201
0.24	0.96	0.76	1.05	0.05	0.17	4.2	0.98	30	7590	253

3.4.2.2. Sampling Design

The sampling design was based on the 2012 Zimbabwe Master Frame developed from the ZIMSTAT 2012 Population Census framework. Zimbabwe has 10 provinces and each province is divided into districts and each district into administrative smaller units, which are the wards. Each ward is divided into enumeration areas (EAs). The adolescents were selected using a multi-stage stratified cluster design.

Stage 1 - All the country's ten provinces were included in the sample. Adolescent girls were proportionately sampled using the distribution of female adolescents by province. Table 3.3 presents the distribution of female adolescents by province, according to the 2012 Population Census.




Table 3.3: Distribution of Adolescent Population by Province

Province	Population of Females Adolescents	Population% Distribution	No of Districts per province	No of selected districts	No of HH to be sampled	No of EA to be sampled
Bulawayo	186265	11	1	1	840	28
Harare	235439	14	4	2	1080	36
Manicaland	213521	13	10	5	990	32
Mashonaland Central	132759	8	10	5	600	20
Mashonaland East	155752	9	11	6	720	24
Mashonaland West	173941	10	13	7	750	26
Matebeleland North	94428	6	9	5	840	14
Matebeleland South	86811	5	10	5	450	13
Midlands	199209	12	14	7	420	30
Masvingo	186265	11	10	5	900	28
Total	**1664390**	**100**	**92**	**48**	**7590**	**253**

Stage 2 - The second stage involved selection of 50% of districts per province weighted by the population of female adolescents in the district. The number of districts amounted to 48 instead of 46 because of rounding off of odd numbers of districts. In total, 48 out of 92 districts (according to 2012 Population Census) were sampled across all the ten provinces. Table 3.5 summarizes the sampled districts by adolescent population and proportionate sampling of households and EAs.




Table 3.4: Distribution of Selected Districts by Province, EAs and Household (HH) Sampled

Province	Selected Districts	Females Population	Proportion Sampling	No of EAS Sampled	Total HH targeted
Bulawayo	Bulawayo urban	80852	0.619	28	840
Harare	Harare Urban	163339	0.793	29	870
	Chitungwiza	42751	0.207	7	210
Manicaland	Chipinge Rural	38039	0.245	8	240
	Makoni	32050	0.207	7	210
	Buhera	31757	0.205	7	210
	Mutare Rural	30971	0.200	6	180
	Mutare Urban	22140	0.143	5	150
Mash Central	Mazoe	25819	0.276	6	180
	Mt Darwin	25216	0.270	5	150
	Guruve	14305	0.153	3	90
	Centenary	14115	0.151	3	90
	Bindura Rural	14071	0.150	3	90
Mash East	Goromonzi	25178	0.230	6	180
	Murehwa	23658	0.217	5	150
	Mutoko	16781	0.154	4	120
	Mudzi	15901	0.146	3	90
	Chikomba	14537	0.133	3	90
	UMP	13205	0.121	3	90
Mash West	Hurungwe	38886	0.282	7	210
	Zvimba	29494	0.214	6	180
	Makonde	17982	0.130	3	90
	Chegutu Rural	17086	0.124	3	90
	Sanyati	12455	0.090	2	60
	Mhondoro Ngezi	11117	0.081	2	60
	Kadoma	10873	0.079	2	60
Masvingo	Chiredzi Rural	33407	0.258	7	210
	Masvingo Rural	25801	0.199	6	180
	Gutu	25115	0.194	5	150
	Zaka	23660	0.182	5	150
	Mwenezi	21726	0.167	5	150
Mat North	Binga	18112	0.251	4	120
	Thsolotsho	15934	0.221	3	90
	Nkayi	14732	0.204	3	90
	Lupane	13347	0.185	3	90
	Umguza	10111	0.140	2	60
Mat South	Gwanda Rural	14618	0.235	3	90
	Insiza	12475	0.200	3	90
	Bulilima	12411	0.199	3	90
	Matobo	12393	0.199	3	90
	Beitbridge Rural	10362	0.166	2	60
Midlands	Gokwe South	38727	0.246	7	210
	Gokwe North	30073	0.191	6	180
	Mberengwa	24996	0.159	5	150
	Kwekwe Rural	21398	0.136	4	120
	Gweru Urban	19027	0.121	4	120
	Kwekwe urban	12173	0.077	2	60
	Gweru Rural	10714	0.068	2	60
Total		1203890		**253**	**7590**




Stage 3 - Enumeration areas (EAs) were the sampling units for stage three. In each district, the ZIMSTAT Census EA was used as the primary sampling unit. All EAs in selected districts were clustered according to the four geographic locations. Within each cluster, a random sample of EAs was selected. The number of EAs was determined proportionately to the population of female adolescents in each cluster. EAs were randomly selected from each cluster. A total of 253 EAs were targeted.

Stage 4 - The sampling unit was the household. A listing of households was carried out in each of the selected EAs by ZIMSTAT. Maps were drawn for each of the clusters and households were purposively selected based on the existence of adolescent girls in the household. In EAs where there were more than the required 30 households with adolescent females, households were randomly selected till the cluster size is reached per EA. In EAs where there were less than 30 households with eligible respondents or where there were listed households without eligible respondents owing to listing errors or where the targeted respondents were not available for the period the enumeration team was in that EA, neighborhood sampling strategy was employed to replace the ineligible households or households where the respondents were not available to ensure that the minimum required number of households per EA was reached. A minimum of 7,590 households from the 48 districts were targeted for inclusion in the study.

Stage 5 - The final stage involved the selection of the adolescent girl. In each sampled household, adolescents were categorized by their age group (10-14 and 15-19 years) if both were available. In situations where both adolescents were available, one adolescent girl was picked in each age category, otherwise only one adolescent was picked per household. For households with more than one eligible adolescent girl in one age category, one of them was randomly identified for interview using Kish tables.

Inclusion/exclusion criteria: The following inclusion/exclusion criteria was used to determine the adolescent girls to include in the study:

(i) Female adolescents aged 10-19 years according to the definition by the World Health Organization (WHO) regardless of whether they had experienced a pregnancy or not.
(ii) Adolescent girls whose parents/guardians had granted written informed consent and who themselves granted written assent were included in the study.
(iii) Adolescent girls whose parents/guardians did not grant written informed consent or who themselves did not grant written assent were excluded from the study. Adolescent girls were further excluded from the study if they declined to grant assent even if their parents/guardians had consented to their participation.

3.4.2.3. Data Collection Tool for the Survey

Interviewer-administered questionnaires were developed and translated and back-translated for content validity and consistency checks. The questionnaire developed was age-specific sensitive, paying particular attention to questions that can be asked




to younger adolescents (10-14) in comparison to the older adolescents (15-19). The structured questionnaire was administered through face to face interviews using tablets. The questionnaire covered the individual factors and some of the interpersonal, organisational, community public policy factors. The FGDs and KII also covered the interpersonal, organisational, community and public policy factors. The questionnaire had the following sections:

Individual Level

a. Demographic characteristics - age, marital status, education, religion, religiosity, ethnicity, residence, wealth status and employment status.
b. Knowledge on pregnancy and contraceptives.
c. Attitudes towards adolescent pregnancy and contraceptive use.
d. Sexual behaviour - ever had sex, age at first sex, age of sexual partner, forced/coerced sex, transactional/commercial sex, alcohol and drug abuse, contraceptive use at first and current sex.
e. Pregnancy history - ever been pregnant, age at first pregnancy, age of partner at first pregnancy, whether wanted or not, marriage outcome, abortion, still births, complications during delivery.
f. Self-efficacy - confidence in refusing sex.

Interpersonal

a. Orphanhood status
b. Pressure from relatives and friends to get pregnant
c. Pressure from relatives to get pregnant
d. Sisters/friends who became pregnant before age 20
e. Discussion with parents/guardians on SRH issues

Organisational Level

a. Socio-cultural practices
b. Religious influence
c. Ethnicity
d. Access and utilisation of SRH information and services

Community level

a. Sexual abuse
b. Access to media and ICT

The fully developed translated questionnaire was programed onto electronic tablets. The tablets were used for data collection through face-to-face interviews with an option to use English, Shona or Ndebele.

3.4.2.4. Data Collection

There were a total of 10 data collection teams, one in each province. Each data collection team had 4 members, comprising 3 enumerators and one team leader. Team leaders participated in data collection as well as community sensitisation, obtaining




permission from local authorities to conduct the study and spearheading mobilisation of adolescents. In each province, a Ministry of Health official was appointed as the team leader.

Enumerators were females aged 20-24 years with the ability to speak one of the major local languages including Shona and Ndebele. The enumerators were trained in gender-based violence (GBV) and basic counselling, and were instructed to refer cases to specific service providers to handle those who may be affected by sensitive questions around sexual activity and GBV. To facilitate the referral process, enumerators provided respondents with information on GBV and counselling services available in their specific province or district.

Leaders and communities at various levels were sensitised about the study before data collection began to ensure that the study teams accessed households and adolescents without difficulty.

The survey took a total 13 weeks as follows:

- Two weeks was spent on training and pre-testing of the study tool. The training, which was residential, was done in Harare with the full participation of trainees and facilitators. Pre-testing of the tools was done in Mashonaland East and West and Harare.
- Listing of households in all the survey districts and EAs was conducted with the assistance of ZIMSTAT. Survey maps were developed for each district to help the research teams have easy access to households with the target population - female adolescents. In Matabeleland North and South Provinces, errors were encountered in the listing exercise as some of the districts where listing was done were not part of the study sample. These districts where listing was wrongly done were discarded and replaced by the correct districts where listing had not been done. Research teams in the two provinces were given maps of the correct districts and had to identify households with eligible respondents, i.e. female adolescents, through referrals and snowballing.

In some EAs, some of the listed households did not have the eligible respondents, either because the households were wrongly listed or the identified adolescents were not available at the time of the study. These households were replaced with unlisted households within the same EAs. Actual data collection took 49 days.

3.4.3. Focus Group Discussions

Focus group discussions (FDGs) were conducted among the following groups:

- Adolescent girls aged 15-19 years to cover factors at individual, interpersonal, organizational, community and public policy level;
- Adolescent boys aged 15-19 years to cover factors at interpersonal and community level; and
- Community members: *parents/guardians; political, traditional and religious leaders; traditional*




medical practitioners; village health workers; police; and school officials; and community-based organizations (CBOs) working with adolescents to cover community and organizational factors.

3.4.3.1. FGDs among Adolescent Girls aged 15-19

Focus group discussions were conducted among adolescent girls to determine the contributing factors and consequences of adolescent pregnancy.

Sample Size: Each team conducted two FGDs, taking into account the geographic and age group (15-19). In total, 20 FGDs were conducted among adolescent girls.

Recruitment: Adolescent girls, in and out of school aged 15-19 were selected to participate in the FGDs. These were selected from the adolescents that were not included in the survey. Each group consisted of 6-8 participants who were identified by the community.

Inclusion/exclusion criteria: The following inclusion/exclusion criteria was used to identify adolescent girls to participate in the interviews:

a. Participants were adolescent girls aged 15-19 years.
b. Adolescent girls whose parents/guardians granted written informed consent and who themselves granted written assent were included in the FGDs.
c. Adolescent girls whose parents/guardians refused to grant written informed consent or who themselves refused to grant written assent were excluded from the FGDs. Girls were further excluded from participating in the interviews if they declined to grant assent even if their parents/guardians consented to their participation.
d. Adolescents who had not participated in the survey to minimize respondent fatigue.

3.4.3.2. FGDs among Adolescent Boys aged 15-19

Focus group discussions were conducted among adolescent boys aged 15-19 years to determine their role in perpetuating or preventing adolescent pregnancy by looking at their attitudes and perceptions of adolescent pregnancies. The FGDs also gathered boys' views regarding causes and consequences of adolescent pregnancies. UNFPA (2013) noted that previous studies have failed to address the "role of men and boys in perpetuating and preventing adolescent pregnancy" and thus it was imperative to include boys in this study to find out their role in adolescent pregnancy.

A team of six young male researchers was recruited and trained to specifically conduct FGDs with adolescent boys in the same EAs and communities where FGDs with adolescent girls had been conducted.

Sample Size: In total, 20 FGDs were conducted among adolescent boys, taking into account the geographic (urban and rural) and age group (15-19).

Recruitment: Adolescent boys, in and out of school aged 15-19, were selected to participate in the FGDs. These were randomly selected from the districts and EAs where the survey for adolescent girls were conducted. Each group consisted of 6-8 participants who were identified by the community.

Inclusion/exclusion criteria: The following inclusion/exclusion criteria was used to identify students to participate in the interviews:




- Participants were male adolescents aged 15-19 years.
- Adolescent boys whose parents/guardians granted written informed consent and who themselves granted written assent were included in the FGDs.
- Adolescent boys whose parents/guardians refused to grant written informed consent or who themselves refused to grant written assent were excluded from the FGDs. Boys were further be excluded from participating in the interviews if they declined to grant assent even if their parents/guardians consented to their participation.

3.4.3.3. FGDs among Community Members

FGDs were conducted among community members: *parents/guardians; political, traditional and religious leaders; traditional medical practitioners; village health workers; police; and school officials; and CBOs working on ASRH*. The FGDs gathered information on the community norms and circumstances that shape adolescents' behaviour and their role in promoting or preventing adolescent pregnancies.

Sample Size: Each team conducted one FGD per province. In total, 10 FGDs were conducted among community members.

Recruitment: Each group consisted of 6-8 participants. These were identified in the community. Participants were selected according to the community roles and the connection of these roles to the issue of adolescent pregnancy. Participants were identified with the help of national, provincial and district-level policy makers as well as local administrators.

Inclusion/exclusion criteria: Community members and those representing CBOs working on ASRH who met the following inclusion/ exclusion criteria were included in the study:

a. Male or female adults aged 18 years and above.
b. Participants recognized as community members: parents/guardians; political, traditional and religious leaders; traditional medical practitioners; village health workers; police; and school officials; and CBOs working on ASRH.
c. Participants who granted written informed consent to participate in the study. Those who declined to grant such consent were excluded from the study.

3.4.3.4. Data Collection of FGDs

The FGDs were recorded using digital recorders to capture the discussions verbatim. There was a facilitator to lead the discussions and a note taker. FGD guides were developed to facilitate and guide the discussions.

3.4.4. Key Informant Interviews

Key informant interviews were conducted with key stakeholders and program managers from institutions implementing ASRH programs, at national and sub-national levels. These provided data on the policies, strategies, provision of ASRH services and interventions to address the pregnancy issues. The interviews were recorded to capture all the information as note taking




could have missed some of the critical points. The key informants were selected to represent the following:

- ASRH service providers at community level: clinics, hospitals, youth-friendly centres, community-based organizations and non-governmental organizations (NGOs) working with adolescents.
- Key stakeholders at national and sub-national level: MoHCC; Ministry of Primary and Secondary Education; Ministry of Women Affairs, Gender and Community Development; Ministry of Youth, Indigenisation and Empowerment; Ministry of Public Service, Labour and Social Welfare, ZNFPC, UNFPA, ZYC and NGOs dealing with adolescents.

Sampling: Key informants at both national and sub-national levels were purposively selected.
Data Collection*:* One-on-one interviews were conducted with key informants. Relevant documents were also collected during these interviews.

3.5. Data Management and Quality Assurance

A number of quality assurance processes and measures were put in place to ensure the collection of high quality data. The following specific measures were taken by the study team to ensure data quality:

3.5.1. Pre-fieldwork Quality Assurance Measures

Selection of Survey Team: A total of 10 teams (each comprising 3 enumerators and team leader) were put in place to undertake the survey in all the 10 provinces in the country. Another team six male researchers was also constituted to conduct FGDs for boys in all the 10 provinces. Enumerators and team leaders were selected on the basis of their relevant qualifications and familiarity and experience in the area of adolescent sexual and reproductive health. The enumerators and supervisors all had tertiary level education and were fluent in the vernacular languages of provinces they were deployed to.

Training of survey team: The survey team went through a 7-day intensive training in Harare to equip them with research skills to collect high quality data. Another five day training was conducted for the male researchers who conducted FGDs for boys.
The training focused on the following key issues:

- Background and rationale for the study
- Qualitative and quantitative research methods
- Skills for conducting qualitative and quantitative research focusing on adolescents including contacting procedures, consent forms and confidentiality, interview procedures in the field, basic counselling and referrals
- Research ethics
- Using tablets in surveys
- Data quality, data management and data transmission protocol

Pre-testing and Pilot-testing of the research process and tools: This was done as a quality assurance measure to assess the feasibility of using the proposed research methodology and tools, validity of tools and technical skills of the researchers. This allowed for the refining of the tools and the research process before commencement of actual field work.




Pre-testing of the research tools was conducted in Mashonaland East, West and Harare Provinces after training of research assistants. To minimise on costs and time, the pre-test was carried out in nearby provinces with rural and urban characteristics.

The study was pilot tested to assess the following:

- The feasibility of approaching households and asking permission
- The processes of community entry
- Pre-testing the research tools
- Time required to complete the interview
- Time required for electronic data entry using the tablets
- Identify other field logistical problems that are likely to be encountered during research implementation

The tools were also pre-tested to:

- To assess the sequencing/flow of the questions and content validity of the questions in relation to the target age group
- Assess the clarity of instructions in the questionnaire
- Estimate the time needed to administer the questionnaire
- Feasibility of administering the questionnaire using tablets
- Feasibility of conducting FGDs using voice recorders
- Assess the content validity and clarity of translations

3.5.2. Fieldwork data collection management and quality assurance

A data management protocol was developed and used in the training of enumerators and team leaders. The following processes were adhered to by the research teams during fieldwork.

Data Collection by Enumerators

Every morning the team leader allocated each enumerator households that they should cover on that particular day. The enumerators then took an inventory of all the materials and gadgets that they needed to conduct the household interviews and ensured that they were in working order. Any challenges noted were immediately reported to the team leader for remedial action. Enumerators also ensured that the survey material, information and gadgets were kept safely, securely and confidential and were not accessed by anyone who was not part of the survey team.

Once the team leaders were satisfied that everything was in order, the survey teams then went out to conduct interviews. They carried with them the tablets, back-up hard copy questionnaires, and consent forms. The enumerators kept a daily log book detailing the number of households and questionnaires successfully completed, number of incomplete questionnaires and reasons thereof, number of refusals and reasons thereof, number of call backs and results of the call backs and number of households selected through neighbourhood sampling. At the end of each day, the team leaders went through the daily logbooks with the enumerators and discussed any challenges encountered and take immediate remedial action if need be. If challenges could not be resolved by the team, the survey management team was conducted immediately by the team leaders.




Quality Checks by Team Leaders

Team leaders went through a checklist of materials and gadgets for the survey to ensure that all the required materials were available and that the gadgets were in functional order on a daily basis. Any challenges were immediately reported to the relevant people at the national level.

Team leaders set out the daily work at the beginning of the workday. In the field, the team leaders were responsible for community entry protocol and attended to any challenges that the enumerators encountered during the course of the day. At the end of each day, the enumerators brought back their data and surrendered it to the team leader who uploaded it to his/her laptop and checked the data for completeness and consistency. Any deficiencies noted by the team leader were immediately discussed with each enumerator. After being satisfied with the quality of data from each enumerator, all the data was transmitted to the central server via a pre-programmed internet link by the team leader. Any challenges encountered in transmitting data were communicated to the data management team.

Team leaders kept a daily logbook which was used to monitor the progress of the survey work in every EA, district and province. In the logbooks, they recorded:

- The number of households and respondents successfully interviewed
- Number of incomplete interviews and reasons thereof
- The response, refusal and non-contact rates and reasons thereof
- The number of call-backs and outcomes of calls
- Number of households selected using neighbourhood sampling/shadow households

To ensure data security, team leaders ensured that no one who was not part of the research team had access to the data. Team leaders and enumerators created access codes for the laptops and the tablets. Hard copy of questionnaires and consent forms were kept secured by the team leader and were surrendered to the Principal Investigator at the end of the survey.

Central Server Data Management

Data was transmitted to the central server by the team leaders from the 10 provinces on a daily basis. Once the data was in the central server, it was accessed by the data management and IT team. The data management team checked data for completeness and consistency. The data management team also crosschecked with the provincial teams to verify that the amount of data received was the same as that sent by the survey teams. If there were any inconsistencies in terms of data sent by the provincial teams and that received at the central server, an investigation was made to establish the reason for the inconsistency and the problem was rectified.

Some challenges encountered at the central server include loss of server connectivity due to technical challenges experienced by the internet service provider. This resulted in the central server being down for a couple of days and provincial teams failing to send their data to the central server. As a remedy, data was extracted by the data management teams directly from the team leader's laptops through Team Viewer during the period that the central server was down. The data had several backup platforms, from the tablets, supervisors' laptops, central server and the four laptops of the data management and survey management team.




***Data Security*:** the central server was securely located with the data management team and was only accessed by the IT and data management team. When the data was transmitted to the four laptops of the data management team, it was only accessible by the team as the laptops were secured through individual access codes. All the research material, such as hardcopy questionnaires and consent forms, are safely secured by the Principal Investigator while all the gadgets used in the survey such as laptops, tablets and voice recorders, are secured in the Ministry of Health and Child Care.

National Supervision Teams: Supervision teams comprising the consultants, MoHCC and ZNFPC visited all the field teams in the 10 provinces to monitor the research process for quality assurance purposes. Specifically, the objectives of the supervision visits were:

- To discuss the research process with the teams and identify challenges that the teams were facing and agree on remedial action to be taken to address the identified gaps and challenges.
- To check on team adherence to the data collection protocol including district entry protocol, community and household entry, identification of households, consent processes, interview procedures and data management processes.
- To assess quality of data collected in terms of missingness, consistency and completeness and provide feedback to the supervisors and the teams for corrective action to be taken

After supervision field visits, reports were prepared and shared with the survey team for comments and feedback.

3.6. Data Cleaning and Analysis

3.6.1. Quantitative Data

Data from the field was edited for accuracy, missing data, validity and consistency by the data management team. After this first stage of data cleaning, a data cleaning workshop was held in Harare where the survey management team, team leaders and one team member from all the 10 provinces participated. During this workshop, a question by question content analysis of the data was carried out to check for consistency, missing data, validity and reliability and the functionality of the skip/jump patterns on the tablets. Descriptive tables were run during this workshop for each variable on the questionnaire and data validity issues were discussed.

After data cleaning, the datasets were exported to Statistical Package for Social Sciences (SPSS) Software for analysis. Specific indicators were generated in SPSS in line with the list of indicators that have been outlined in the study's conceptual framework. The data was weighted to represent at national level. See Table 3.5.




Table 3.5: Unweighted and Weighted Number of Households and Adolescents

Province	Number			
	Unweighted Household	Weighted Household	Unweighted Adolescents	Weighted Adolescents
Bulawayo	831	122,543	852	126,669
Manicaland	975	204,869	1027	216,119
Mashonaland Central	592	138,647	620	144,480
Mashonaland East	712	173,430	743	181,632
Mashonaland West	736	197,229	793	214,230
Matabeleland North	405	89,076	418	92,006
Matabeleland South	414	74,697	432	77,835
Midlands	894	146,173	911	149,335
Masvingo	823	177,846	868	188,326
Harare	956	176,782	992	183,259
Total	**7338**	**1,501,292**	**7656**	**1,573,890**

Cross-tabulations and statistical tests were used to enhance interpretation of data, where necessary. The chi-square test was used to test for statistically significant associations. The data was analysed to assess individual factors that are associated with pregnancy. The prevalence of pregnancy was calculated as a proportion with 95% confidence. This was followed by bi-variate analysis where potential factors were compared between those who are pregnant and those who are not pregnant. Bi-variate analysis was done to compare individual factors that are significantly associated with pregnancy. For continuous variables, e.g. age at first sex, independent T-test was used for comparison after checking for assumptions of normality. If the data assumptions were not met, the non-parametric test (Mann-Whitney U Test) were used. For the categorical variables, the chi-square test was used to test the associations for each variable between the two groups. In situations where 20% or more of the cells have expected frequencies less than 5, the Fishers Exact Test was used. Logistic regression was conducted to determine the factors contributing to adolescent pregnancy. The factors were divided into the different levels according to the Ecological Model, i.e. individual, inter-personal, organisational, community and national.

3.6.2. Qualitative Data

Transcription of the FGDs on voice recorders was done before the FGDs were translated into English. During the data cleaning workshop, key issues emerging from FGDs and Key Informant interviews were discussed using thematic focus areas of the research. The NVIVO software package was used to analyse qualitative data from the FGDs. Thematic analysis, in line with study objectives, was used to interpret qualitative data from the FGDs. Qualitative data was analysed and interpreted to support the quantitative data generated above.

3.7. Ethical Considerations

Ethical Review

The study protocol was sent to the Medical Research Council of Zimbabwe (MRCZ) for ethical approval.




Informed Consent

Written informed consent was obtained from each research participant who was above 18 years. For participants below 18 years, consent from the parent/guardian was obtained, after which an assent was obtained from the adolescent. An opportunity to ask questions until they fully understood the study and the implications of their participation was given to the participants. Participants were assured of confidentiality and the right to withdraw from the research at any time of the interview. Confidentiality was maintained by avoiding names and other identifiers.

Risks

Measures were taken to identify, anticipate and minimize any potential long-term effects on individuals or groups as a result of the research. In cases where some participants felt uncomfortable while relating their experience of pregnancy or sexual abuse, interviewers were instructed to stop recording and stop the interview depending on the wishes of the research participant. FGD participants were informed that the discussions would be tape-recorded. Researchers were trained to refer adolescents to specific services as needed. The enumerators were trained in gender-based violence (GBV) and basic counselling, and were instructed to refer cases to specific service providers to handle those who may be affected by sensitive questions around sexual activity and GBV.

Participant Reimbursement

Participants were compensated for their time and involvement in the study. If participants were asked to travel in order to be interviewed, a small gratuity and refreshment (US$5) was offered according to MRCZ requirements. A small gratuity in the form of transport allowance and refreshment was also be offered to ***those*** participants taking part in focus group discussions (US$5).

Confidentiality and Anonymity

All participants' information and records that contain names or other personal identifiers, such as informed consent forms, are being stored securely in a locked cabinet in areas with access limited to study staff to minimize potential breach of confidentiality. All names and personal circumstances, which may lead to the identification of research participants, were modified in data transcriptions and translations; respondents were identified through a unique identifying number only. Codes were used to identify participants in the quantitative, key informant and in-depth interviews. Pseudonyms were used to identify participants in the FGDs. Except for FGDs; all other interviews were conducted in private. Data is being stored in a password-protected computers that only the study team can access.

Participant Withdrawal

Research participants were allowed to withdraw from the study at any stage and for any reason.

Potential Benefits

This research provides tangible and practical benefits to address adolescent pregnancy in Zimbabwe:

- The recommendations will help government representatives and policy makers to address more appropriately the SRH needs of adolescents, thereby improving services and prevention activities.
- The methodologies and breadth of the research's target groups will offer recommendations adapted to the settings where the research takes place, together with invaluable and highly relevant information for public health policy-makers throughout the country.




- Outcomes will be sensitive to gender and other cross-cutting issues.
- The dissemination plans also offer details on the benefits for national/international program implementers, policy makers, and government representatives.
- Local stakeholders involved in the study (study sites, research partners, and other institutions linked to the study) will receive feedback of results and will be presented with key findings from the study.
- A number of policy briefs and publications will also be produced, and the study will be presented in local, regional and international conferences on SRH and adolescents' health.





4. Results

4.1. Research Targets and Outputs

Table 4.1 shows research outputs vis-à-vis research targets. A total of 253 EAs were targeted for the survey across all the 10 provinces. However, two EAs in Harare could not be enumerated owing to access challenges. In each EA, 30 eligible households were targeted to make a total of 7,590 households for the entire survey. However, 7,338 households were interviewed representing a 97% response rate. There were 100 refusals (78 by parents or guardians and 78 by targeted adolescents themselves). A total of 7,656 adolescents were interviewed. In households where there were adolescents aged 10-14 and 15-19 years, the two from each category were interviewed. A total 152 targeted and listed households did not have eligible respondents. Fifty Focus Group discussions were conducted across all the 10 provinces and 161 key informants were interviewed.

Table 4.1: Research Targets vs. Achievements

	Targets		Outputs						
					No. of Refusals				
Province	**No. of EAs**	**No. of House-holds**	**No. of EAs**	**No. of House-holds**	**Household/ Parents**	**Individual Adolescent**	**No. of FGDs**	**No. of Question-naires Competed**	**KIIs**
Bulawayo	28	840	28	831	15	7	5	852	13
Harare	36	1080	34	956	8	-	5	992	6
Manicaland	33	990	33	975	3	1	5	1027	15
Mashonaland Central	20	600	20	592	29	8	5	620	10
Mashonaland East	24	720	24	712	7	1	5	743	21
Mashonaland West	25	750	25	736	1	-	5	793	19
Masvingo	28	840	28	823	7	-	5	868	14
Matabeleland North	15	450	15	405	1	1	5	418	16
Matabeleland South	14	420	14	414	3	3	5	432	17
Midlands	30	900	30	894	4	1	5	911	30
National	**253**	**7590**	**251**	**7338**	**78**	**22**	**50**	**7656**	**161**




4.2. Pregnancy

4.2.1. Pregnancy Prevalence

The study sought to establish the level of adolescent pregnancy in the country. Figure 4.1 presents the proportion of adolescents who have been pregnant by different age groups and by rural-urban residence. Overall, 9% of the adolescent girls aged 10-19 years had ever been pregnant. The proportion of adolescent girls who had ever been pregnant increases with age from 0.2% among the 10-14 years-olds to 33% among adolescent girls aged 18-19 years. The proportion of adolescents aged 15-19 who had been pregnant was 17%. The percentage of adolescents aged 15-19 who had been pregnant is quite negligible such that no further analysis was done on that group in relation to pregnancy. Again, the overall fertility of 9% for all adolescent girls aged 10-19 years again is too small for further analysis. Therefore, the analysis on pregnancy is based on adolescent girls aged 15-19 years, which is further broken down into 15-17 and 18-19 years. Adolescent pregnancy among adolescents aged 15-19 years was higher in rural areas (20%) than in urban areas (9%).

Figure 4.1: Distribution of Adolescent Girls Ever been Pregnant by Age and Rural-Urban Residence

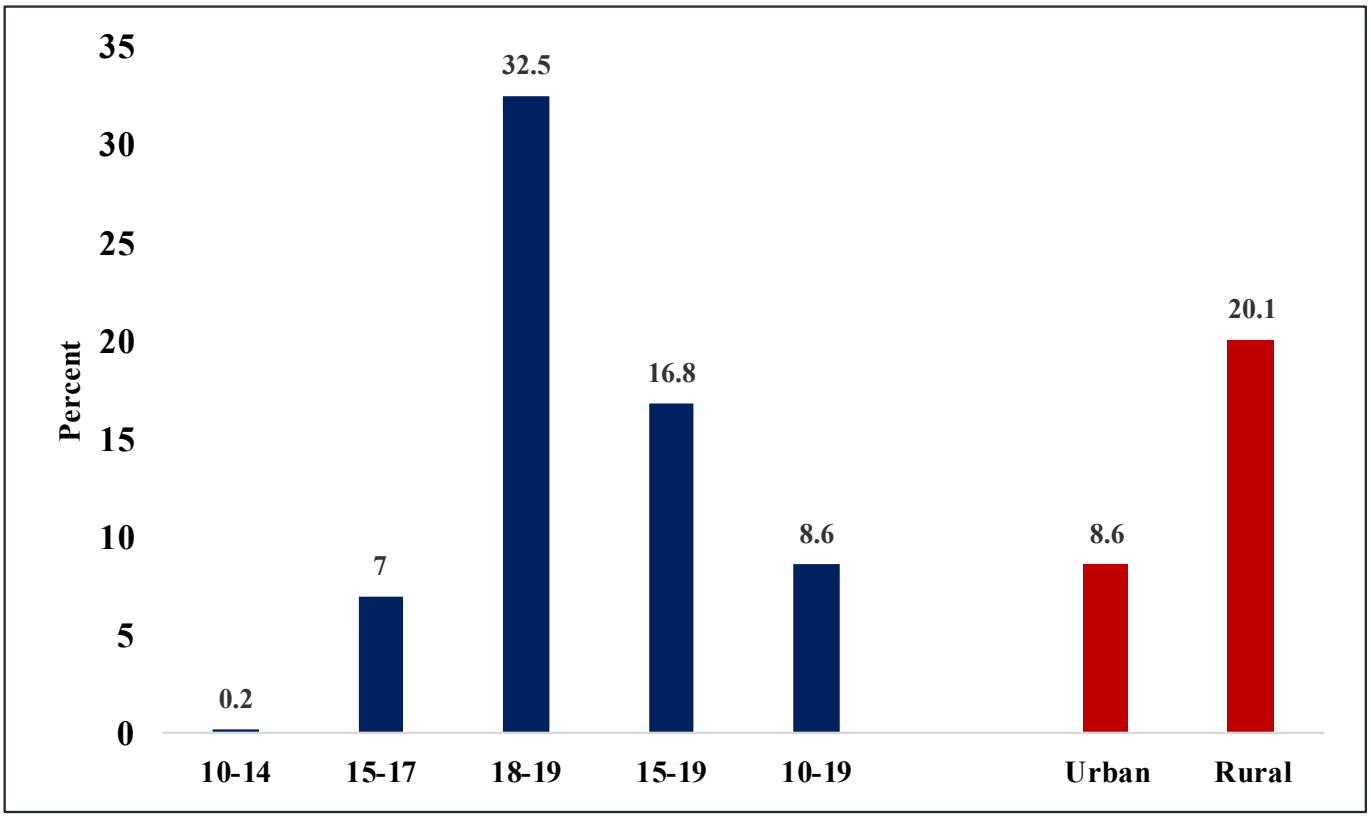
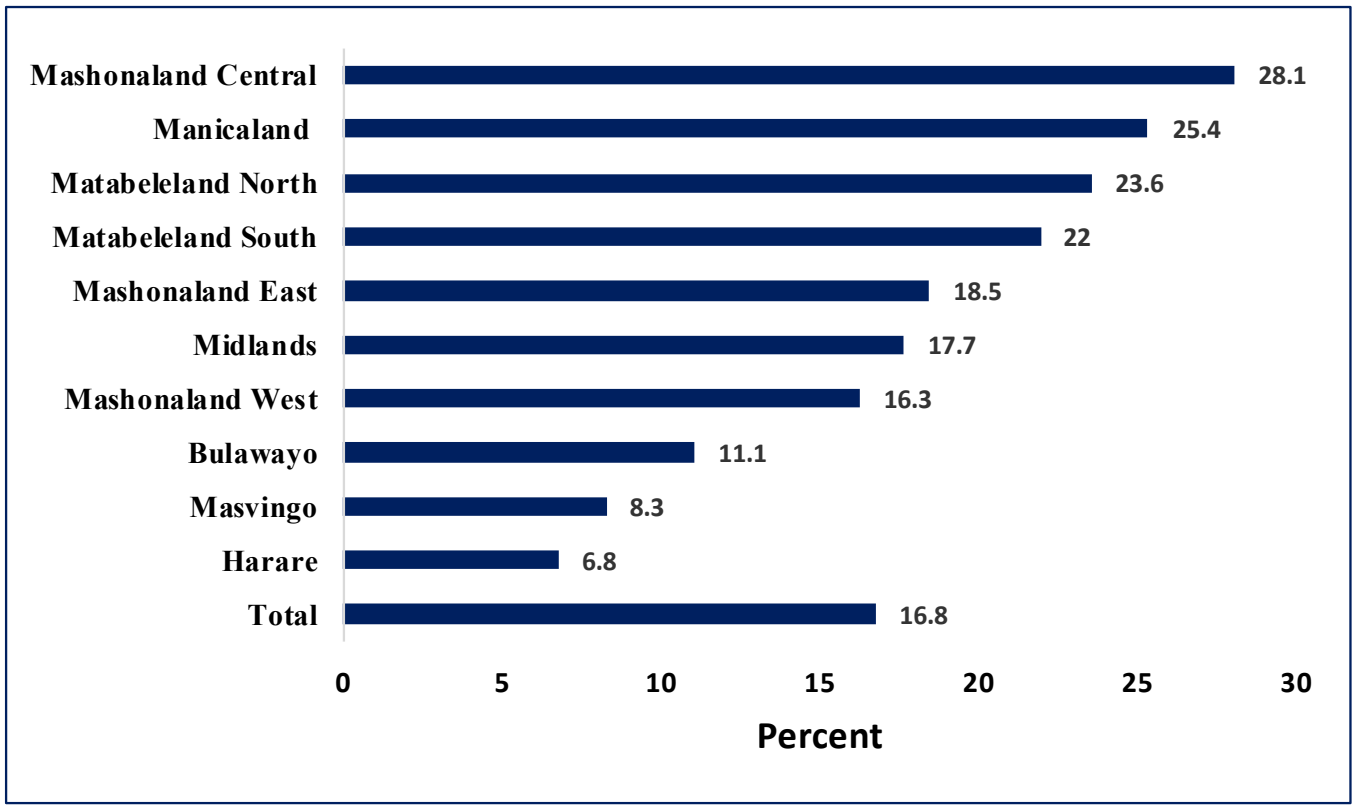


Figure 4.2 shows that adolescent pregnancy prevalence was highest in Mashonaland Central (28%), followed by Manicaland (25%) and Matabeleland North (24%) and lowest in Harare (7%).




Figure 4.2: Distribution of Adolescents aged 15-19 Years Ever been Pregnant by Province



The data presented above shows that adolescent pregnancy is a national problem. This finding was also confirmed by the focus group discussions (FGDs) and the key informant interviews. Focus group discussions with adolescent girls and boys aged 15-19 years interviewer-administered questionnaire interviews with adolescents, and interviews with key informants revealed that teenage pregnancy is a problem in the country. This is reiterated by some of the girls from both urban and rural areas:

Many cases. Girls are falling pregnant and these are friends, classmates and school mates. (Urban Girl)

The number is high and keeps going higher. "Sokuvame kakhulu" (It's now very common) (Rural Girl)

You could also check with the enrolment list at schools as more girls enrol for form one places, let's say 80 female students but as time passes by and as they get to reach Form 4, they might have reduced to up to 40, most of them would be married or will have fallen pregnant (Rural Girl).

There are so many girls who are falling pregnant because those girls are getting into relationships while they are still young that's why they fall pregnant while very young. (Urban Girl)

What's happening is young girls are no longer steady or have guidance about marriage, girls are now getting married at, 13, 14, years and they no longer wait to reach 18 and above. Abusive living conditions and bad treatment at home push young girls into marriage (Rural Girl)




….we will keep on blaming the parents because children are being abused at 13 years but some are not allowed to report cases of rape to police. Children are forced into early marriages after rape by parents and other community members alleging that going to the police will not reverse what had already happened and if they do not get married the child might turn to be deviant as a result of rape. This is happening despite the explanations of rape given by the victims (Rural Girl)

Even the boys found adolescent pregnancy to be a problem and mentioned that the cases are even higher than the ones known as some of these pregnancies are aborted.
A lot of girls are falling pregnant "varipo hobho". (Urban boy)

Adolescent pregnancy is on the rise although same abort. "… dzakazara kuno uku. Nyaya dzenhumbu dziriko asi kuti chinhu chatinoona ndechekuti nhumb dziri kubviswa dzisati dzaonekwa" (*The issue of pregnancies exists, but most of these are being aborted before being noticed*). (Rural boy)

Key informants also acknowledged that adolescent pregnancy is a problem in the country. They mentioned that there was an increase in fertility among adolescent girls, especially in rural areas and some urban pockets. Some of the key informants had this to say:

There is an increase in fertility among adolescent girls, especially in rural areas and some urban pockets such as Chitungwiza and Epworth. Fertility levels are available at national and provincial levels. Thus, we need to know the fertility at district level for the district level picture.

Adolescent pregnancy is a social problem, therefore there is need for urgent attention. There is need to know what the driving force is.

However, low pregnancy rates were reported in some of the FGDs from Matabeleland North, Harare and Bulawayo. Even within the urban areas, lower adolescent pregnancy rates were reported in low-density areas while high rates were reported in high-density areas.

4.2.2. Reason for the First Pregnancy among Adolescent Girls aged 15-19 Years who had Experienced Pregnancy

Table 4.2 shows distribution of adolescent girls aged 15-19 years who had experienced a pregnancy by reason for first pregnancy by age group. The main reasons given for first pregnancy were *unplanned pregnancy* (48%) and *wanted a child* (45%). Of concern is the proportion who *did not think they would fall pregnant* (23%). Another concern on children is the proportion of adolescent girls aged 15-17 years who got pregnant because of *early marriage* (19%), showing the prevalence of child marriage in the country and 11% who were *sexually abused or raped*, indicating child sexual abuse .




Table 4.2: Distribution of Adolescents aged 15-19 by Reason for First Pregnancy by Age Group

	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Reason for First Pregnancy						
Unplanned	16394	47.6	48646	48.7	65040	48.4
Wanted a child	16167	47.0	44137	44.1	60304	44.9
Did not think I would fall pregnant	8136	23.6	22105	22.1	30241	22.5
Early marriage	6417	18.6	18573	18.6	24990	18.6
Did not know about condom use/contraceptives	5142	14.9	7801	7.8	12944	9.6
Sexual violence/abuse/Rape	3746	10.9	6853	6.9	10599	7.9
Partner refused condom use	1059	3.1	8185	8.2	9244	6.9
Coerced into having sex	3063	8.9	7225	7.2	10288	7.7
Condom failure	1109	3.2	3051	3.1	4160	3.1
I refused to use condom	91	0.3	2181	2.2	2272	1.7

Table 4.3 presents the reasons given by the adolescent girls aged 15-19 years for their first pregnancy by rural-urban residence. The reason most cited among rural adolescent girls was *wanted a child* (47%) while their urban counterparts was *unplanned* 62%). The proportion of adolescent girls who got pregnant from early marriage was higher in rural areas (21%) than in urban areas (8%), indicating the vulnerability of rural girls to adolescent pregnancy.

Table 4.3: Distribution of Adolescents aged 15-19 by Reason for First Pregnancy by Rural-Urban Residence

	Urban-Rural Residence				Total	
	Rural		Urban			
	Number	%	Number	%	Number	%
Reason for First Pregnancy						
Unplanned	52818	46.1	12222	61.5	65040	48.4
Wanted a child	53992	47.1	6312	31.8	60304	44.9
Did not think I would fall pregnant	24360	21.3	5881	29.6	30241	22.5
Early marriage	23498	20.5	1492	7.5	24990	18.6
Did not know about condom use/contraceptives	12591	11.0	353	1.8	12944	9.6
Sexual violence/abuse/Rape	8479	7.4	2120	10.7	10599	7.9
Partner refused condom use	7506	6.6	1737	8.7	9244	6.9
Coerced into having sex	9169	8.0	1119	5.6	10288	7.7
Condom failure	2547	2.2	1613	8.1	4160	3.1
I refused to use condom	1956	1.7	315	1.6	2272	1.7




4.2.3. First Pregnancy History

Table 4.4 selected pregnancy-related issues among ever been pregnant adolescent girls aged 15-19 years. The majority of the adolescent girls who had ever been pregnant had fallen pregnant once (82%). The majority of the adolescents who became pregnant were not working (68%) when they became pregnant for the first time.

Table 4.4: Distribution of Adolescent Girls Ever been Pregnant by First Pregnancy History and Age

Pregnancy History	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Number of times fallen pregnant						
Once	30,697	89.2	79,577	79.6	110,274	82.0
More than once	3,734	10.8	20,414	20.4	24,148	18.0
Activity Status at First Pregnancy						
Not working	23,703	68.8	67,895	67.9	91,597	68.1
In secondary school	7,306	21.2	19,687	19.7	26,993	20.1
Working	2,848	8.3	9,778	9.8	12,626	9.4
In primary school	574	1.7	1,515	1.5	2,089	1.6
At college or university/apprenticeship	0	0.0	736	0.7	736	0.5
Other	0	0.0	237	0.2	237	0.2
Declined to answer	0	0.0	143	0.1	143	0.1
Total	**34,431**	**100.0**	**99,991**	**100.0**	**134,421**	**100.0**

4.3. Factors Contributing to Adolescent Pregnancy - Univariate and Bivariate Analysis

4.3.1. Individual Level

4.3.1.1. Age and Marital Status

Table 4.5 presents the weighted distribution of adolescent girls aged 10-19 years included in the survey by age. The age distribution shows that 49% of the adolescent girls were aged 10-14 years and 51% aged 15-19 years.

Table 4.5: Distribution of Adolescent Girls by and Age

Age Group	Number	%
10-14	775,061	49.2
15-19	798,830	50.8
10-19	**1,573,890**	**100.0**

Association between Adolescent Pregnancy and Age

Table 4.6 shows the percentage distribution of adolescent girls aged 15-19 years who had ever been pregnant by age. Adolescent pregnancy increases with age from 2% among adolescent girls aged 15 years to 42% among adolescent girls aged 19 years ($p<0.001$).




Table 4.6: Distribution of Adolescents aged 15-19 Years Ever been Pregnant by Age

Demographic Factors	Number of Adolescents aged 15-19	Ever been Pregnant %	P - value
Age			
15	3,669	1.9	<0.001
16	9,747	6.1	
17	21,014	14.7	
18	36,905	22.4	
19	63,086	44.2	
Total	**798,830**	**16.8**	

Table 4.7 shows the distribution of adolescent girls by marital status and age. The age group 15-19 years was broken down into ages 15-17 years and 18-19 years in order to capture child/early marriage issues. About 7% of the adolescent girls aged 10-19 years were married, 26% among adolescent girls aged 18-19 years and 7% among the adolescent girls aged 15-17 years, indicating the prevalence of child marriage in the country.

Table 4.7: Distribution of Adolescents by Marital Status and Age

	Age Group							
	10-14		15-17		18-19		Overall 10-19	
Marital Status	Number	%			Number	%	Number	%
Never married	774,152	99.9	456787	92.9	215,083	70.0	1,446,022	91.9
Married	909	0.1	32057	6.5	81,141	26.4	114,108	7.3
Divorced/Separated/Widowed	0	0.0	2685	0.6	11,076	3.6	13,761	0.9
Total	**775,061**	**100.0**	**491529**	**100.0**	**307,301**	**100.0**	**1,573,890**	**100.0**

Table 4.8 presents the distribution of the ever married adolescent girls aged 10-19 years by selected marital variables. The majority of the female adolescents aged 10-19 years who had ever been married reported that they were married once (98%). Eight percent of the adolescent girls aged 10-19 years reported that their most recent or current partner was chosen by someone else. The main reasons that led to the first marriage mentioned by the respondents were *eloped* (24%) and *pregnancy* (23%). This shows that adolescent pregnancy is one of the contributing factors to marriage.




Table 4.8: Distribution of Adolescents aged 10-19 Years Ever been Married by Selected Marital Variables

	Total 10-19	
	Number	%
Number of times one has been married		
Once	103,524	98.0
More than one	2,108	2.0
Whether someone chose her current/most recent partner		
Yes	8,953	8.5
No	96,320	91.2
Don't know	132	0.1
Declined to answer	227	0.2
Total	**105,631**	**100.0**
Reasons for first marriage		
Eloped	32,418	23.9
Pregnancy	31,359	23.1
Wanted to get married	19,309	14.2
Cultural	6,762	5.0
Forced/arranged marriage	5,908	4.3
Religious reasons	4,242	3.1
Escape poverty	3,448	2.5
Emotional/ physical abuse	655	0.5
Other	576	0.4
Total	**135,817**	**100.0**

Association between Adolescent Pregnancy and Marital Status

Marital status was associated with adolescent pregnancy. The proportion of adolescent girls aged 15-19 years who had been pregnant was highest among the married (83%) compared to the never married (4%) ($p<0.001$). See Table 4.9. However, it is difficult to prove antecedent event as marriage is a predictor of pregnancy.

Table 4.9: Distribution of Adolescents aged 15-19 Years Ever been Pregnant by Marital Status

Background Variables	Number of Adolescents aged 15-19	Ever been Pregnant %	P - value
Marital Status			
Never married	671,870	4.4	<0.001
Married	113,199	83.2	
Separated/divorced	13,761	79.4	
Total	**798,830**	**16.8**	




4.3.1.2. Schooling Status

Table 4.10 presents the distribution of adolescent girls by education background and age. The majority of the adolescent girls aged 10-19 years were currently attending school (71%). More than half of the adolescent girls aged 10-19 years who were still at school were in upper primary and lower secondary school (32% and 45%, respectively). Most of the adolescent girls who were not attending school had attained lower secondary education (65%).

Table 4.10: Distribution of Adolescent Girls by Education Background and Age

Socio-Economic Characteristics	Age Group				Overall 10-19	
	10-14		15-19			
	Number	**%**	**Number**	**%**	**Number**	**%**
Currently attending school						
Attending school	734,510	94.8	379,070	47.5	1113580	70.8
Not attending school	40,551	5.2	419,760	52.5	460311	29.2
Total	**747,224**	**100.0**	**762,384**	**100.0**	**1,509,608**	**100.0**
Current level of education - Girls attending school						
Lower Primary	229,237	31.2	2,903	0.8	232,140	20.8
Upper primary	336,395	45.8	23,207	6.1	359,602	32.3
Lower Secondary	168,426	22.9	327,806	86.5	496,232	44.6
Upper Secondary	0	0.0	18,453	4.9	18,453	1.7
Tertiary	452	0.1	6,701	1.8	7,153	0.6
Total	**734,510**	**100.0**	**379,070**	**100.0**	**1,113,580**	**100.0**
Level of education attained - Girls not attending school						
Never been to school	1,628	4.0	3,098	0.7	4,726	1.0
Lower Primary	12,313	30.4	13,380	3.2	25,693	5.6
Upper Primary	22,278	54.9	95,320	22.7	117,598	25.5
Lower Secondary	4,072	10.0	294,306	70.1	298,377	64.8
Upper Secondary and above	260	0.6	13,656	3.3	13,916	3.0
Total	**40,551**	**100.0**	**419,760**	**100.0**	**460,311**	**100.0**

Adolescent girls who were not in school were asked the main reason why they were not attending school. Table 4.11 presents the distribution of adolescent girls who were not in school by main reason of not attending school and level of education attained. The main reason cited for not attending school was the inability to afford the fees (45%), followed by having completed O'/A' levels (35%). Seven percent got married (4% *aged 15-17 years and 0.4% aged 10-14 years*) while 5% became pregnant (4% *aged 15-17 years and 2% aged 10-14 years*). This shows the prevalence of child marriage and childbearing.




Table 4.11: Distribution of Adolescent Girls by Main Reason for not attending School

Main Reason for not Attending School	Age Group								Total 10-19	
	10-14		15-17		18-19		15-19			
	Number	%	Number	%	Number	%	Number	%	Number	%
Could not afford fees	32,406	79.9	90,432	51.6	82,976	33.9	173,407	41.3	205,813	44.7
Completed O/A Level	0	0.0	56,496	32.2	102,799	42.1	159,294	37.9	159,294	34.6
Got Married	154	0.4	7,522	4.3	24,011	9.8	31,533	7.5	31,687	6.9
Got Pregnant	856	2.1	6,600	3.8	14,594	6.0	21,194	5.0	22,050	4.8
Waiting for results	1,867	4.6	2,741	1.6	4,769	2.0	7,509	1.8	9,376	2.0
Not interested in school	146	0.4	1,966	1.1	4,643	1.9	6,609	1.6	6,756	1.5
Illness	1,547	3.8	2,412	1.4	1,599	0.7	4,011	1.0	5,558	1.2
Failed	337	0.8	429	0.2	4,688	1.9	5,117	1.2	5,454	1.2
Parents/guardian refused	909	2.2	1,696	1.0	1,685	0.7	3,381	0.8	4,290	0.9
Needed to earn money/ work	337	0.8	365	0.2	943	0.4	1,308	0.3	1,644	0.4
Distance	266	0.7	489	0.3	521	0.2	1,010	0.2	1,276	0.3
Other	1,127	2.8	4,183	2.4	806	0.3	4,989	1.2	6,116	1.3
Don't know	385	0.9	0	0.0	397	0.2	397	0.1	781	0.2
Declined to answer	214	0.5	0	0.0	0	0.0	0	0.0	214	0.0
Total	**40,551**	**100.0**	**175,331**	**100.0**	**244,431**	**100.0**	**419,759**	**100.0**	**460,310**	**100.0**

4.3.1.3. Employment Status

Table 4.12 shows employment status of the respondents and the type of employment for those who were employed. Five percent of adolescent girls aged 10-19 years currently working, 1% and 6% among those aged 10-14 years and 15-17 years, showing the prevalence of child labour. The majority of the adolescent girls aged 10-19 years who were currently working were in informal employment (53%).

Table 4.12: Distribution of Adolescents by Current Employment of Adolescents by Age

Work Status	Age Group								Total 10-19	
	10-14		15-17		18-19		15-19			
	Number	%	Number	%	Number	%	Number	%	Number	%
Currently working										
Working	9,459	1.2	27,352	5.6	35,816	11.7	63,168	7.9	72,627	4.6
Not working	765,602	98.8	464,177	94.4	271,485	88.3	735,661	92.1	1,501,263	95.4
Total	**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**798,829**	**100.0**	**1,573,890**	**100.0**
Type of work										
Formal employment	259	2.7	4,659	17.0	6,123	17.1	10,782	17.1	11,040	15.2
Informal employment	2,152	22.7	15,336	56.1	21,091	58.9	36,427	57.7	38,579	53.1
Piece jobs/ part time	7,049	74.5	7,357	26.9	8,603	24.0	15,960	25.3	23,008	31.7
Total	**9,459**	**100.0**	**27,352**	**100.0**	**35,816**	**100.0**	**63,168**	**100.0**	**72,627**	**100.0**




4.3.1.4. Sexual Activity

First Sexual Encounter

Early sexual activity has been cited in many studies as contributing to adolescent pregnancies. Figure 4.3 shows that 13% of the adolescent girls aged 10-19 years had a sexual experience. Sexual experience increases with age from 1% among adolescent girls aged 10-14 years to 46% among those aged 18-19 years. The proportion of adolescent girls who had a sexual experience was higher in rural areas (14%) than in urban areas (11%). The percentage of adolescents aged 10-14 years is too small for further analysis and thus analysis is based on the 15-19 years.

Figure 4.3: Distribution of Adolescent Girls by Ever had Sex and Age Group

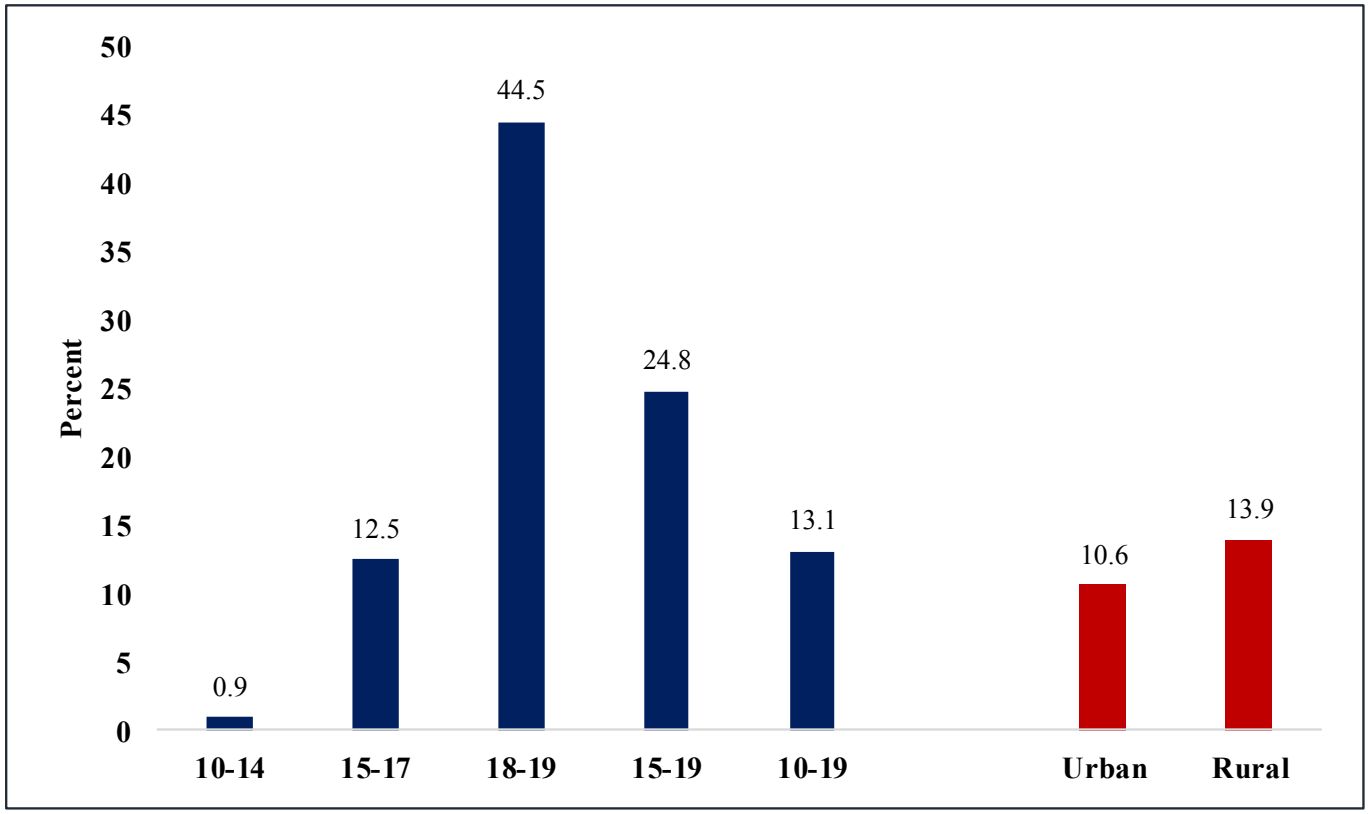


Table 4.13 presents the distribution of adolescent girls by sexual experience and age. The mean age at first sex was 16 years for adolescents aged 15-19 years and the mean age of sexual partner at first sexual encounter was 22 years, a difference of 6 years. Most of the adolescent girls had their first sexual encounter with their boyfriends (62%) and husbands (30%). Most of the adolescents aged 15-19 years who had sexual experience (79%) had one life time sexual partner by the the time of the survey.




Table 4.13: Distribution of Adolescents aged 15-19 who had Ever Had Sex by First Sexual Experience Variables and Age

First Sexual Experience Variables	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Mean Age at First Sex						
Mean Age at First Sex of the Adolescent Girl (sd)	15.5 (1.3)		16.9 (1.5)		16.2 (1.4)	
Mean Age of Sexual Partner at First sex (sd)	21.0 (4.3)		22.1 (4.6)		21.5 (4.4)	
Relationship to First Sexual Partner						
Boyfriend	39,069	63.4	84,403	61.8	123,473	62.3
Husband	15,980	25.9	43,578	31.9	59,559	30.0
Relative	1,937	3.1	2,808	2.1	4,746	2.4
Casual acquaintance	1,642	2.7	1,252	0.9	2,895	1.5
Cohabiting partner	989	1.6	1,468	1.1	2,457	1.2
Raped/ Don't know	783	1.3	1,296	0.9	2,079	1.0
Neighbour	386	0.6	816	0.6	1,203	0.6
Declined to answer	211	0.3	633	0.6	1,044	0.5
Other	620	1.0	215	0.2	834	0.4
Number of Life time sexual partners						
Only 1	50,410	81.8	105,177	77.1	155,587	78.6
2 to 3	9,190	14.9	26,597	19.5	35,786	18.1
More than 3	2,018	3.3	4,676	3.4	6,694	3.4
Total	**61,618**	**100.0**	**136,450**	**100.0**	**198,067**	**100.0**

*One declined to answer subsequent questions on sexual behaviour as she was raped.

Table 4.14 presents the main reasons for first sexual encounter mentioned by the sexually experienced girls. The main reasons cited for having sex by adolescent girls aged 15-19 years include the following: *wanted to show love to partner* (23%), *it just happened* (22%) and *just wanted to have sex* (19%). More than half of the sexually experienced adolescent girls aged 10-14 years were raped/forced on their first sexual encounter (54%).




Table 4.14: Distribution of Adolescent Girls who had Ever Had Sex by Main Reason for First Sexual Encounter

	Age Group						Total 15-19	
	10-14		15-17		18-19			
	Number	%	Number	%	Number	%	Number	%
Main Reason for Having Sex at First Sexual Encounter								
Wanted to show love to partner	353	5.0	13,193	21.4	31,864	23.4	45,057	22.8
It just happened	1226	17.5	14,556	23.6	29,705	21.8	44,260	22.4
Just wanted to have sex/experiment	1611	23.0	11,110	18.0	25,579	18.8	36,689	18.5
Pressured by partner/ boyfriend	32	0.5	7,320	11.9	15,411	11.3	22,732	11.5
Marriage	0	0.0	6,019	9.8	14,664	10.8	20,683	10.5
Raped/Forced	3765	53.7	5,464	8.9	10,343	7.6	15,806	8.0
Given gifts/money	0	0.0	842	1.4	2,262	1.7	3,104	1.6
Declined to answer	0	0.0	769	1.2	931	0.7	1,700	0.9
Wanted a child	0	0.0	31	0.1	1,260	0.9	1,292	0.7
Don't know	0	0.0	405	0.7	537	0.4	942	0.5
Other	20	0.3	1,877	3.0	3,699	2.7	5,576	2.8
Total	**7007**	**100.0**	**61,586**	**100.0**	**136,254**	**100.0**	**197,840**	**100.0**

Current Sexual Activity

Current sexual activity was measured by having sex in the 12 months prior to the survey. Eighty-six percent of the adolescent girls aged 15-19 years with sexual experience had sex in the last 12 months, with 93% having had one sexual partner (See Table 4.15).

Table 4.15: Distribution of Sexually Active Adolescents aged 15-19 by Current Sexual Activity

	Age Group				Total 15-19	
	15-17		18-19			
Current Sexual Activity	Number	%	Number	%	Number	%
Had sexual intercourse in the last 12 months						
Yes	51,647	83.8	117,885	86.4	169,532	85.6
No	9,971	16.2	18,564	13.6	28,536	14.4
Total	**61,618**	**100.0**	**136,450**	**100.0**	**198,068**	**100.0**
Number of sexual partners in the last 12 months						
Only one	47,349	91.7	109,914	93.2	157,262	92.8
2 to 3	4,298	8.3	7,972	6.8	12,270	7.2
Total	**51,647**	**100.0**	**117,885**	**100.0**	**169,532**	**100.0**




4.3.1.5. Contraceptive Use

Twenty-eight percent of adolescents aged 15-19 years who had ever had sex used contraceptives during their first sexual encounter. The main reasons cited by adolescent girls aged 15-19 years for not using contraceptives during first sexual encounter include the following: intention to become pregnant/wanted a child (26%), did not know about contraceptives (16%) and never thought they would get pregnant (13%). See Table 4.16.

Table 4.16: Distribution of the Adolescent who had Ever Had Sex Girls by Contraceptive Use, Reasons for not Using Contraceptives at First Sex and Age

	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Use of Contraceptives on First Sexual Encounter						
Used contraceptives	16,238	26.4	38,411	28.2	54,650	27.6
Did not use contraceptives	45,380	73.6	98,038	71.8	143,418	72.4
Total	**61,618**	**100.0**	**136,449**	**100.0**	**198,068**	**100.0**
Reason for not Using Contraceptives at First Sexual Encounter						
Intention to become pregnant/wanted a child/married	10,209	22.5	26,623	27.1	36,834	25.7
Did not know about contraceptives	9,082	20.0	14,416	14.7	23,499	16.4
Never thought would get pregnant	4,806	10.6	14,063	14.3	18,869	13.2
Forced sex/rape	6,295	13.9	10,341	10.5	16,636	11.6
Partner refused	3,225	7.1	6,751	6.9	9,976	7.0
Never thought about it	2,494	5.5	6,685	6.8	9,179	6.4
Did not know where to get contraceptives	2,891	6.4	5,385	5.5	8,276	5.8
Church forbids	2,447	5.4	4,063	4.1	6,510	4.5
Sex was unprepared	1,259	2.8	3,549	3.6	4,809	3.4
Trusted each other/ Had been tested together with partner	592	1.3	1,700	1.8	2,292	1.6
Feeling of embarrassment obtaining contraceptive methods	822	1.8	794	0.8	1,616	1.1
Lack of money to buy contraceptive methods	499	1.1	428	0.4	927	0.6
Other	758	1.7	3,238	3.3	3,996	2.8
Total	**42,885**	**100.0**	**98,036**	**100.0**	**143,419**	**100.0**

On current sexual activity, 48% of sexually active adolescent girls aged 15-19 years who had sex in the last 12 months used contraceptives. The contraceptives mainly used at last sexual encounter were the condom (42%) and the pill (39%). See Table 4.17.




Table 4.17: Distribution of Sexually Active Adolescent Girls aged 15-19 by Current Sexual Activity and Age

Current Sexual Activity	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Use of contraceptives in the last sexual encounter						
Used contraceptives	18,803	36.4	61,669	52.3	80,472	47.5
Did not use contraceptives	32,843	63.6	562,17	47.7	89,060	52.5
Total	**51,647**	**100.0**	**117,885**	**100.0**	**16,953**	**100.0**
Method of contraception used in the last sexual encounter						
Male condom	10,406	55.3	23,536	38.2	33,942	42.2
Pill	6,735	35.8	24,632	39.9	31,368	39.0
Injectable	773	4.1	5,710	9.3	6,483	8.1
Implant	387	2.1	4,345	7.0	4,732	5.9
Female condom	128	0.7	1,415	2.3	1,544	1.9
Withdrawal	0	0.0	622	1.0	622	0.8
Other	374	2.0	1,408	2.3	1,782	2.2
Total	**18,803**	**100.0**	**61,669**	**100.0**	**80,472**	**100.0**

4.3.1.6. Alcohol/Drug Abuse

Adolescent girls aged 15-19 years who had ever had sex were asked whether they or their partner were under the influence of alcohol/drugs when they first had sex. Eight percent of adolescent girls who had ever had sex reported that they or their partner were under the influence of alcohol/drugs on their first sexual encounter. See Table 4.18.

Table 4.18: Distribution of Adolescent Girls aged 15-19 Years by Alcohol/Drug Use on First Sexual Encounter by Age

	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Under the Influence of Alcohol/Drugs						
Yes	4,920	8.0	10,862	8.0	15,783	8.0
No	55,747	90.5	122,634	89.9	178,380	90.1
Don't know	951	1.5	2,954	2.2	3,905	2.0
Total	61,618	100.0	136,450	100.0	198,068	100.0

Association between Adolescent Pregnancy and Alcohol/Drug Abuse

Table 4.19 shows the association between adolescent pregnancy and alcohol abuse during first sexual encounter. Adolescent girls who reported that they or their partner were under the influence of alcohol/drugs when they first had sex were less likely to have experienced a pregnancy (56%) compared to those not under the influence of alcohol/drugs (69%) ($p<0.01$).




Table 4.19: Distribution of Adolescent Girls aged 15-19 Years by Ever been Pregnant and Alcohol/Drug Use on First Sexual Encounter

	Number	Ever Been Pregnant %	P - value
Under the Influence of Alcohol/Drugs			
Under the influence of alcohol	8,787	55.7	0.001
Not under the influence of alcohol	122,825	68.9	
Don't know	2,589	66.3	

4.3.1.7. Self-Efficacy

Self-efficacy was measured by asking adolescent girls *how confident they were that they would be able to refuse someone trying to have sex or being touched sexually if they did not want*. Table 4.20 shows that 22% of the adolescent girls aged 10-19 years were not confident that would be able to refuse someone trying to have sex or being touched sexually if they did not want. Lack of confidence was higher among adolescent girls aged 10-14 years (26%) than those aged 15-19 years (18%).

Table 4.20: Distribution of Adolescent Girls aged 10-19 Years by Confidence in Refusing Sex

	Age Group								Total 10-19	
	10-14		15-17		18-19		15 -19			
	Number	%	Number	%	Number	%	Number	%	Number	%
Confidence in Refusing Sex or Being Touched Sexually										
Confident	570,455	73.6	407,012	82.8	251,439	81.8	658,451	82.4	1,228,906	78.1
Not confident	204,606	26.4	84,517	17.2	55,862	18.2	140,379	17.6	344,985	21.9
Total	**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100**

Association between Adolescent Pregnancy and Confidence in Refusing Sex

Table 4.21 presents the association between adolescent pregnancy prevalence and confidence in refusing sex. Adolescent girls aged 15-19 years who had no confidence in refusing sex if someone was trying to have sex with them or be touched sexually when they did not want to have sex were more likely to have experienced a pregnancy (20) compared to those who were confident (16%) ($p<0.001$). A similar association was found among adolescent girls aged 15-17 years and 18-19 years.




Table 4.21: Association between Adolescent Pregnancy among Adolescents aged 15-19 Years and Confidence in Refusing Sex

	Ever Been Pregnant						Total 15-19		
	Age Group								
	15-17			18-19					
	Number	%	P-Value	Number	%	P-Value	Number	%	P - value
Confidence in refusing someone if you did not want to have sex or be touched sexually									
Confident	28,119	6.9	0.001	78,523	31.2	0.001	106,642	16.2	0.001
Not Confident	6,312	7.5		21,468	38.4		27,780	19.8	

4.3.1.8. Knowledge on Pregnancy and Attitudes on Pregnancy, Sexuality Issues and Condoms

Knowledge on Pregnancy

Adolescent girls aged 10-19 years were asked about "*when a girl is **most likely** to become pregnant during her menstrual cycle*". Twelve percent were able to identify the correct period, which is halfway between the end of one period and the beginning of the next menstrual period. The rest were wrong whether they claimed to know or not. See Table 4.22.

Table 4.22: Knowledge about when a Girl is most likely to Become Pregnant

When is a girl most likely to become pregnant during her menstrual cycle	Age Group						Total 10-19	
	10-14		15-17		18-19			
	Number	%	Number	%	Number	%	Number	%
During her menstrual period	31,860	4.1	21,774	4.4	10,248	3.3	63,881	4.1
Immediately after her menstrual period	102,922	13.3	161,088	32.8	125,124	40.7	389,134	24.7
Immediately before her menstrual period	41,166	5.3	75,760	15.4	52,267	17.0	169,193	10.7
Halfway between the end of one period and the beginning of the next menstrual period	37,694	4.9	84,260	17.1	64,011	20.8	185,964	11.8
Other	5,816	0.8	4,714	1.0	2,379	0.8	12,910	0.8
Don't know	555,603	71.7	143,933	29.3	53,272	17.3	752,808	47.8

To determine knowledge of pregnancy, adolescent girls aged 10-19 years were asked a set of questions, in addition to knowledge about when pregnancy is mostly likely to occur. Table 4.23 presents the percentage distribution of respondents who gave the correct responses to the statements. The majority of the adolescents (85%) reported that a girl *can avoid getting pregnant by abstaining from sex*. Just below half of the adolescents (44%) said it was not true *that washing genitals immediately after sex prevent pregn*ancy. As the age increases, girls gain more knowledge.




Table 4.23: Distribution of Adolescents aged 10-19 years by Knowledge of Pregnancy and Age

		Age Group						Total 10-19	
		10-14		15-17		18-19			
		Number	%	Number	%	Number	%	Number	%
Q402.Can a girl avoid getting pregnant by abstaining from sex?	Yes	597,776	77.1	449,432	91.4	288,193	93.8	1,335,401	84.8
Having a shower after having sex	Not true	199,927	25.8	306,351	62.3	225,423	73.40	731,700	46.5
Jumping up and down after sex prevents pregnancy	Not true	192,822	24.9	287,275	58.4	211,229	68.7	691,326	43.9
Washing genitals immediately after sex prevents pregnancy	Not true	191,391	24.7	288,967	58.8	208,460	67.8	688,818	43.8
A girl can avoid pregnancy if she urinates immediately after sexual intercourse	Not true	186,722	24.1	270,141	55.0	196,837	64.1	653,700	41.5
Having sex while standing prevents pregnancy.	Not true	164,891	21.3	269,876	54.9	204,646	66.6	639,413	40.6
A girl can get pregnant the first time she has sexual intercourse	TRUE	198,609	25.6	226,084	46.0	184,533	60.0	609,226	38.7

A total score on pregnancy was calculated. Four percent of the girls had comprehensive knowledge of pregnancy. Knowledge on comprehensive knowledge increases with age. See Table 4.24.

Table 4.24: Distribution of Adolescent Girls by Comprehensive Knowledge of Pregnancy and Age

	Age Group						Total 10-19	
	10-14		15-17		18-19			
	Number	%	Number	%	Number	%	Number	%
Knowledge on Pregnancy								
No Comprehensive Knowledge	768,338	99.1	462,837	94.2	282,598	92.0	1,513,773	96.2
Comprehensive Knowledge	6,723	0.9	28,692	5.8	24,702	8.0	60,118	3.8
Total	**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**1,573,890**	**100.0**

Attitudes on Pregnancy, Sexuality Issues and Condoms

Table 4.25 shows the statements on attitudes towards adolescent pregnancy, sexuality issues and condoms. The responses to the statements presented show the positive attitude, meaning that they disagree to adolescents getting pregnant. The majority of adolescent girls (94%) disagreed with the statement that *it is okay for adolescent girls to get pregnant*. A quarter of the girls disagreed with the statement that *it would be embarrassing to buy contraceptives from the store*.




Table 4.25: Distribution of Adolescent Girls aged 10-19 Years by Attitude on Pregnancy and Condom Use

Attitude towards Pregnancy		10--14		15-17		18-19		10—19	
		Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
It is okay for adolescent girls to get pregnant	Disagree	717,164	92.5	469,637	95.5	287,033	93.4	1,473,834	93.6
It is okay for girls below 20 years to get married to Younger men/boys	Disagree	663,117	85.6	435,719	88.6	269,431	87.7	1,368,267	86.9
Girls should wait until they are older (18 years +) before they have sex.	Agree	640,284	82.6	447,926	91.1	276,524	90.0	1,364,734	86.7
It's okay for adolescent girls to have sex with a steady boyfriend	Disagree	647,192	83.5	423,902	86.2	248,746	80.9	1,319,840	83.9
It is okay for girls below 20 years to get married to Older men	Disagree	633,364	81.7	395,729	80.5	226,997	73.9	1,256,091	79.8
It is okay for girls below 20 years to get married to Same age men/boys	Agree	375,690	48.5	228,846	46.6	124,520	40.5	729,056	46.3
It would be embarrassing to buy contraceptives from the store	Disagree	139,830	18.0	128,961	26.2	128,148	41.7	396,939	25.2
Contraceptive (condom & pills) use is a sign of promiscuity	Disagree	139,260	18.0	123,541	25.1	96,525	31.4	359,326	22.8
I believe contraceptives should be used in a marriage set up.	Disagree	110,342	14.2	121,390	24.7	107,152	34.9	338,884	21.5
If your sexual partner wants to use a condom, you would suspect that he may be having sex with someone else	Disagree	101,959	13.2	132,637	27.0	101,517	33.0	336,113	21.4
I would feel uncomfortable carrying contraceptives with me	Disagree	103,542	13.4	105,778	21.5	104,689	34.1	314,008	20.0
Sex does not feel as good when you use a condom	Disagree	60,111	7.8	72,035	14.7	62,175	20.2	194,321	12.3
Condoms are not safe as they often break or slip off during sex	Disagree	75,593	9.8	51,906	10.6	46,105	15.0	173,604	11.0
Total		**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**1,573,890**	**100.0**




An attitude score was computed. The adolescents who had a positive attitude were against adolescents getting pregnant and those who had a negative attitude supported adolescent pregnancy. About two-thirds of the adolescent girls aged 10-19 years (63%) had negative attitudes towards adolescent pregnancy, sexuality issues and condoms. The negative attitudes decrease as age increases from 74% for those aged 10-14 years to 44% for those aged 18-19 years. See Table 4.26.

Table 4.26: Score on Attitudes on Pregnancy, Sexuality Issues and Condoms

	Age Group						Total 10-19	
	10-14		15-17		18-19			
	Number	%	Number	%	Number	%	Number	%
Attitude on Pregnancy, Sexuality Issues and Condoms								
Negative Attitude	574,085	74.1	288,091	58.6	135,800	44.2	997,976	63.4
Positive Attitude	200,976	25.9	203,438	41.4	171,501	55.8	575,915	36.6
Total	**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**1,573,890**	**100.0**

Association between Adolescent Pregnancy and Knowledge and Attitudes on Adolescent Pregnancy

Adolescents aged 15-19 years who had no comprehensive knowledge of pregnancy were more likely to get pregnant (17%) compared to girls who had comprehensive knowledge (11%) ($p<0.000$). Adolescents aged 15-19 year who had a positive attitude towards pregnancy were more likely to become pregnant (24%) compared to girls who had a negative attitude (10%) ($p<0.001$). See Table 4.27.

Table 4.27: Distribution of Adolescents aged 15-19 Years Ever Pregnant by Comprehensive Knowledge and Attitudes of Adolescent Pregnancy

	Age Groups						Total 15-19		
	15-17			18-19					
	Number	%	P-val-ue	Number	%	P-Val-ue	Number	%	P-Val-ue
Knowledge on Pregnancy									
No Comprehensive Knowledge	33,727	7.3	<0.001	95,070	33.6	<0.001	128,798	17.3	<0.001
Comprehensive Knowledge	704	2.5		4,920	19.9		5,624	10.5	
Attitudes towards pregnancy									
Negative Attitude	13,529	4.7	<0.001	29,702	21.9	<0.001	43,231	10.2	<0.001
Positive Attitude	20,902	10.3		70,289	41.0		91,191	24.3	
Total	**34,431**	**7.0**		**99,991**	**32.5**		**134,422**	**16.8**	




4.3.2. Inter-Personal Level

4.3.2.1. Poverty

Table 4.28 presents the distribution of adolescent girls by household wealth and age. Information on household assets was used to calculate household wealth. These included ownership of items such as bicycle, refrigerator, radio, etc., and dwelling characteristics such as source of drinking water and type of toilet. Table 4.28 shows that the distribution of adolescent girls by wealth quintile was approximately 20% for each wealth quintile.

Table 4.28: Distribution of Adolescent Girls by Wealth Quintile and Age

Wealth Quintile	Age Group				Overall 10-19	
	10-14		15-19			
	Number	%	Number	%	Number	%
Lowest	120,512	15.5	194,491	24.3	315,003	20.0
Second	159,627	20.6	158,554	19.8	318,181	20.2
Middle	156,224	20.2	156,321	19.6	312,546	19.9
Fourth	165,369	21.3	141,530	17.7	306,899	19.5
Highest	173,329	22.4	147,933	18.5	321,262	20.4
Total	**747,224**	**100.0**	**762,384**	**100.0**	**1,509,608**	**100.0**

Poverty was also cited in the FGDs and key informant interviews as one of the factors contributing to adolescent pregnancy. One of the key informants had this to say:

Poverty, due to sleeping arrangements where mother and father sleep in the same room with their children. In fulfilling their conjugal rights, children might see what they are doing and as a result would also want to do the same.

Poverty was also mentioned as a driving force of adolescent pregnancy among FGDs with adolescent girls.

We have a friend who was given to a man, she didn't love him but she had no choice because the parents wanted money. But she doesn't love him that's why she continues dating other men but her mother beats her for doing that…… (Urban Girl).

…at times it is difficult to say NO to sex when the girl is from a poor background and the boy comes from a rich family. If the boy wants me to have sex with him so that he can date me, I would opt to go with it as the pregnancy will be my hope for this relationship that can change you into a better person. Like a girl who grew up in this "Bush" area, she will rejoice to have been associated with a guy from a well- up family (Rural Girl).

Association between Adolescent Pregnancy and Poverty

Several studies have shown that poverty is a factor contributing to adolescent pregnancy. Adolescent girls aged 15-19 years from the lowest wealth quintile were less




likely to have experienced pregnancy (6%) compared to those from the highest wealth quintile (17%) (p<0.001). However, adolescent girls from the middle wealth quintile were more likely to have been pregnant (26%) compared with all the other wealth quintiles. See Table 4.29.

Table 4.29: Distribution of Adolescents aged 15-19 Years Ever been Pregnant by Wealth Quintile

Wealth Quintile	Ever been Pregnant		P - value
	Number	%	
Lowest	194,491	5.7	<0.001
Second	158,554	18.6	
Middle	156,321	25.6	
Fourth	141,530	20.2	
Highest	147,933	17.0	

4.3.2.2. Orphanhood Status

Table 4.30 presents distribution of respondents by Orphanhood status. The majority of the adolescent girls aged 10-19 years were non-orphans (73%), 78% among adolescent girls aged 10-14 years and 67% among those aged 15-19 years. Sixteen percent of the adolescent girls aged 15-19 years were paternal orphans (16%) and 7% double orphans.

Table 4.30: Distribution of Female Adolescents by Orphanhood Status and Age

Orphanhood Status	Age Group				Total 10-19	
	10-14		15-19			
	Number	%	Number	%	Number	%
Non-Orphans	607,244	78.3	534,281	66.9	1,141,525	72.5
Paternal Orphans	101,370	13.1	142,986	17.9	244,356	15.5
Double Orphans	32,885	4.2	77,547	9.7	110,432	7.0
Maternal Orphans	33,561	4.3	44,016	5.5	77,577	4.9
Total	**775,061**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100.0**

Association between Adolescent Pregnancy and Orphanhood Status

Table 4.31 presents adolescent pregnancy by orphanhood status. Adolescent girls aged 15-19 who were orphans were more likely to have ever been pregnant compared to the non-orphans (p<0.001). The most vulnerable adolescent girls aged 15-19 years were the double orphans who were most likely to have ever been pregnant (24%) compared to other non-orphans (14%) (p<0.001). However, for adolescent girls aged 10-14 years, paternal orphans were the most vulnerable to adolescent pregnancy (11%) compared to the maternal orphans and non-orphans (4% and 6%, respectively) (p<0.001).




Table 4.31: Distribution of Adolescents aged 15-19 who Had Ever Been Pregnant by Orphanhood Status and Age

Household Factors	Ever been Pregnant								
	Age Group								
	15-17			18-19			15-19		
	Number	%	P - value	Number	%	P - value	Number	%	P - value
Orphanhood Status									
Non-Orphans	21,261	6.2		55,467	29.1		76,727	14.4	
Paternal Orphans	9,054	11.1		21,230	34.5		30,284	21.2	
Double Orphans	3,170	7.8	0.001	15,783	43.0	<0.001	18,953	24.4	<0.001
Maternal Orphans	946	3.7		7,511	40.8		8,457	19.2	
Total	**34,431**	**7.0**		**99,991**	**32.5**		**134,422**	**16.8**	

4.3.2.3. Pressure/Influence on Pregnancy

Table 4.32 presents the distribution of adolescent girls by ever received pressure from friends and family to get pregnant. Four percent of the adolescent girls aged 10-19 years received pressure from friends to get pregnant. The proportion of adolescent girls who received pressure from friends was highest among those aged 18-19 years (9%). A question on whether one had a sister/sisters who became pregnant can be used both as a proxy measure of adolescent pregnancy and influence on adolescents to get pregnant. Respondents aged 10-19 years were asked if they had a sister/sisters who became pregnant before the age of 20 years. Table 4.32 also shows that 21% of the adolescent girls aged 10-19 years reported that they had a sister/sisters who became pregnant before the age of 20. A third of the adolescent girls aged 10-19 years (32%) reported having a friend/friends who became pregnant before the age of 20. Two percent of adolescent girls received pressure from relatives to get pregnant.



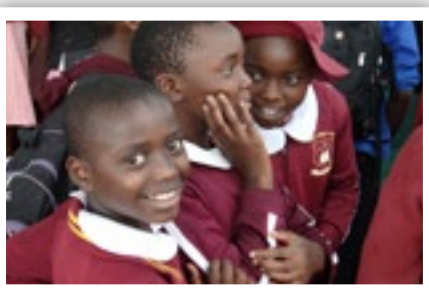





Table 4.32: Distribution of Adolescents aged 10-19 Years by Peer and Family Influence

									Total 10-19	
	10-14		15-17		18 -19		15-19			
			Number	%	Number	%	Number	%	Number	%
Receive(d) pressure from friends to get pregnant										
Yes	16,085	2.1	21,783	4.4	28,004	9.1	49,786	6.2	65,872	4.2
No	758,768	97.9	49,786	95.6	279,297	90.9	749,043	93.8	1,507,811	95.8
Have a sister(s) who became pregnant before the age of 20										
Yes	129,721	16.7	118,022	24.0	89,429	29.1	207,451	26.0	337,172	21.4
No	635,730	82.0	371,380	75.6	215,843	70.2	587,223	73.5	1,222,953	77.7
Don't know	9,403	1.2	2,127	0.4	2,029	0.7	4,156	0.5	13,559	0.9
Have friend(s) who became pregnant before the age of 20										
Yes	108,169	14.0	218,574	44.5	179,548	58.4	398,122	49.8	506,291	32.2
No	666,685	86.0	272,955	55.5	127,753	41.6	400,708	50.2	1,067,393	67.8
Receive(d) pressure from relatives to get pregnant										
Yes	2,554	0.3	8,305	1.7	12,066	3.9	20,371	2.6	22,925	1.5
No	772,299	99.7	483,224	98.3	295,235	96.1	778,459	97.4	1,550,758	98.5
Total	**774,853**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**798,830**	**100.0**	**1,573,683***	**100.0**

* Total number of adolescents does not add up to 1,573,890 because of the weighted girls who declined to answer all questions.

Peer and family pressure was also cited in the FGDs among adolescent girls aged 15-19 years:

What usually happens with our age, is that I might have friends who are dating, and one of them might come to me and entice me to date. You know what happens when people are friends, we usually do what our friends say and what they are doing and we would take it as a good thing... then you might even date a married man...your friend might pressure you into such relationships for material things and money (Rural Girl).




When it comes to mothers, the mothers actually persuade you and say, my daughter if you get married to this guy you will make me happy (Rural Girl).

I think peer pressure. It's like you see your friend with a cell phone and yet you don't have a cell phone your parents didn't buy you one. And they tell you that they will only buy you a phone after completing O levels. So you will be pressurised to have a boyfriend so that he buys you a phone (Urban Girl).

Association between Adolescent Pregnancy and Peer and Family Influence

Table 4.33 shows the association between adolescent pregnancy and peer and family influence. The ever been pregnant adolescent girls aged 15-19 years who received pressure for relatives to get pregnant were more likely to have been pregnant (21%) compared to those who did not receive pressure (17%) ($p<0.001$). The same association was observed among the adolescent girls aged 15-17 years. However, for adolescent girls aged 18-19 years, the finding is the opposite where adolescent girls who had received pressure from relatives to get pregnant were less likely to have been pregnant (21%) compared to those who never received pressure (33%) ($p<0.001$).

The ever pregnant adolescent girls aged 15-19 years who had a sister who became pregnant before the age of 18 years were more likely to have been pregnant (18%) compared to those who did not have a sister who got pregnant. There was a slight difference between adolescent girls aged 15-19 years who had a sister or sisters who became pregnant before the age of 20 years and those who did not have sister(s) who got pregnant before the age of 20 years (16% and 15%, respectively), but a big difference with those who did not know (40%) ($p<0.01$), but this should be taken with caution as those who did not know constitute a very small number.

Adolescent girls aged 15-19 years who received pressure from friends to get pregnant were less likely to have ever been pregnant (15%) compared to those who did not receive pressure (31%) ($p<0.001$). Adolescent girls who had friends who became pregnant before the age of 20 years were less likely to have ever been pregnant (7%) compared to the adolescent girls who had friends who became pregnant (17%) ($p<0.01$).



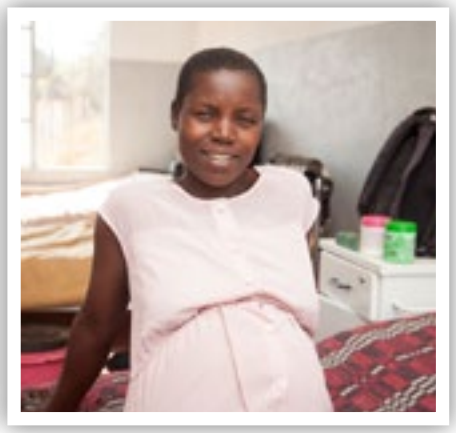





Table 4.33: Distribution of Adolescents aged 15-19 Years who had ever been Pregnant by Peer and Family Influence and Age

	Ever been Pregnant								
	Age Group								
	15-17			18-19			Total 15-19		
	Number	%	P-Value	Number	%	P-Value	Number	%	P - Value
Received pressure from relatives to get pregnant									
Received pressure	1,674	20.2	<0.001	2,500	20.7	<0.001	4,173	20.5	<0.001
Did not receive pressure	32,757	6.8		97,491	33.0		130,248	16.7	
Sister(s) who became pregnant before the age of 20 years									
Yes	11,109	9.4	0.001	26,154	29.2	0.001	37,263	18.0	<0.001
No	22,889	6.2		72,475	33.6		95,364	16.2	
Don't know	434	20.4		1,361	67.1		1,795	43.2	
Received pressure from friends to get pregnant									
Yes	1,925	8.8	<0.001	4,719	16.9	<0.001	6,645	13.3	<0.001
No	32,506	6.9		95,271	34.1		127,777	17.1	
Friend(s) who became pregnant before age 20 years									
Yes	20,166	9.2	<0.001	53,818	30.0	<0.001	73,983	18.6	<0.001
No	14,265	5.2		46,173	36.1		60,438	15.1	

4.3.3. Organisational Level

4.3.3.1. Place of Residence

Table 4.34 presents the distribution of adolescent girls aged 10-19 years included in the survey by place of residence (rural-urban and province). The majority of the respondents were from the rural areas (76%). The highest proportions of the adolescents were from Manicaland and Mashonaland West (14% each) while the smallest proportions were from Matabeleland North and Matabeleland South provinces (6% and 5%, respectively).






Table 4.34: Distribution of Adolescent Girls by Selected Demographic Characteristics and Age

	Age Group					
	10-14		15-19		Overall 10-19	
	Number	%	Number	%	Number	%
Urban-Rural Residence						
Rural	624,682	80.6	568,547	71.2	1,193,229	75.8
Urban	150,379	19.4	230,283	28.8	380,661	24.2
Province						
Bulawayo	55,089	7.1	71,580	9.0	126,669	8.0
Manicaland	105,227	13.6	110,892	13.9	216,119	13.7
Mashonaland Central	74,440	9.6	70,040	8.8	144,480	9.2
Mashonaland East	99,149	12.8	82,484	10.3	181,632	11.5
Mashonaland West	119,678	15.4	94,551	11.8	214,230	13.6
Matabeleland North	41,886	5.4	50,120	6.3	92,006	5.8
Matabeleland South	43,189	5.6	34,646	4.3	77,835	4.9
Midlands	77,730	10.0	71,605	9.0	149,335	9.5
Masvingo	100,430	13.0	87,896	11.0	188,326	12.0
Harare	58,243	7.5	125,016	15.6	183,259	11.6
Total	**775,061**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100.0**

Association between Adolescent Pregnancy and Place of Residence

Place of residence is associated with adolescent pregnancy. Adolescents from rural areas aged 15-19 years were more likely to have experienced pregnancy (20%) compared to their urban counterparts (9%) ($p<0.001$). Adolescent pregnancy was highest in Mashonaland Central (28%) and lowest in Harare (7%) ($p<0.001$). See Table 4.35.

Table 4.35: Distribution of Adolescents aged 15-19 Years Ever been Pregnant by Place of Residence

Environmental Factors	Number of Adolescents aged 15-19	Ever been Pregnant %	P - value
Rural-Urban Residence			
Rural	568,547	20.1	<0.001
Urban	230,283	8.6	
Province			
Bulawayo	7,969	11.1	<0.001
Manicaland	28,186	25.4	
Mashonaland Central	19,678	28.1	
Mashonaland East	15,277	18.5	
Mashonaland West	15,388	16.3	
Matabeleland North	11,830	23.6	
Matabeleland South	7,626	22.0	
Midlands	12,694	17.7	
Masvingo	7,313	8.3	
Harare	8,459	6.8	




4.3.3.2. Ethnicity and Religion

Table 4.36 presents the weighted demographic characteristics of the adolescents aged 10-19 years included in the survey. Most of the respondents were Zezuru (25%) and Karanga (24%) while the least were Kalanga (1%). The majority of the adolescent girls belonged to the Apostolic sect churches (41%), followed by the Protestant and Pentecostal churches (34%). Most of the adolescent girls went to church once a week (63%).

Table 4.36: Distribution of Adolescent Girls by Ethnicity and Religion and Age

	Age Group					
	10-14		15-19		Overall 10-19	
	Number	%	Number	%	Number	%
Ethnicity						
Zezuru	194,741	25.1	199,122	24.9	393,863	25.0
Karanga	188,036	24.3	190,589	23.9	378,626	24.1
Ndebele	106,719	13.8	119,715	15.0	226,434	14.4
Korekore	84,060	10.8	76,252	9.5	160,313	10.2
Manyika	43,607	5.6	57,482	7.2	101,089	6.4
Ndau	44,625	5.8	43,440	5.4	88,065	5.6
Tonga	8,991	1.2	13,977	1.7	22,967	1.5
Kalanga	6,509	0.8	7,216	0.9	13,725	0.9
Foreigner	33,793	4.4	29,809	3.7	63,603	4.0
Other	32,926	4.2	43,092	5.4	76,018	4.8
Don't know	31,054	4.0	18,134	2.3	49,188	3.1
Adolescent's Religion						
Apostolic sect	345,924	44.6	292,862	36.7	638,786	40.6
Protestant/Pentecostal	236,962	30.6	302,411	37.9	539,373	34.3
Other Christian	99,472	12.8	91,130	11.4	190,602	12.1
Catholic	54,906	7.1	66,048	8.3	120,953	7.7
None	27,837	3.6	36,446	4.6	64,283	4.1
African Traditional	5,449	0.7	4,628	0.6	10,077	0.6
Islam	4,041	0.5	4,027	0.5	8,068	0.5
Other	470	0.1	1,278	0.2	1,748	0.1
Frequency of going to church/ religious meeting						
Once a week	488,256	65.3	465,710	61.1	953,966	63.2
More than once a week	173,439	23.2	202,294	26.5	375,733	24.9
A few times a month	51,221	6.9	56,913	7.5	108,134	7.2
A few times a year	34,308	4.6	37,467	4.9	71,775	4.8
Total	**775,061**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100.0**




Association between Adolescent Pregnancy and Ethnicity and Religion

Adolescents of foreign descent were more likely to get pregnant (22%) compared to the Karangas (12%) (p<0.001). Some churches have been reported to influence adolescent marriage, consequently adolescent pregnancy. Adolescents aged 15-19 years who belonged to the Apostolic church and those with no religion were more likely to have been pregnant (23% and 37%, respectively) compared to those belonging to the African traditional and the Catholics (9% and 10%, respectively) (p<0.001). Adolescent girls who attended the church a few times a year were at higher risk of adolescent pregnancy (21%) compared to those who attended more often, like once a week (15%) (p<0.001). See Table 4.37.

Table 4.37: Distribution of Adolescent Pregnancy aged 15-19 Years by Ethnicity, Religion and Religiosity

Background Variables	Number of Adolescents aged 15-19 N=	Ever been Pregnant %	P - value
Ethnicity			
Zezuru	199,122	16.5	<0.001
Karanga	190,589	11.5	
Korekore	76,252	21.1	
Manyika	57,482	16.9	
Ndebele	119,715	20.8	
Tonga	13,977	20.5	
Kalanga	7,216	20.1	
Ndau	43,440	21.2	
Other	29,809	15.6	
Foreigner	43,092	21.6	
Don't know	18,134	8.0	
Religion			
None	36,446	36.8	<0.001
African Traditional	4,628	9.4	
Catholic	66,048	10.1	
Protestant/Pentecostal	302,411	11.3	
Other Christian	91,130	11.3	
Apostolic sect	292,862	23.3	
Islam	4,027	14.4	
Other	1,278	41.0	
Religiosity			
Once a week	465,710	15.1	<0.001
More than once a week	202,294	16.1	
A few times a month	56,913	17.7	
A few times a year	37,467	20.8	
Total	**798,830**	**16.8**	



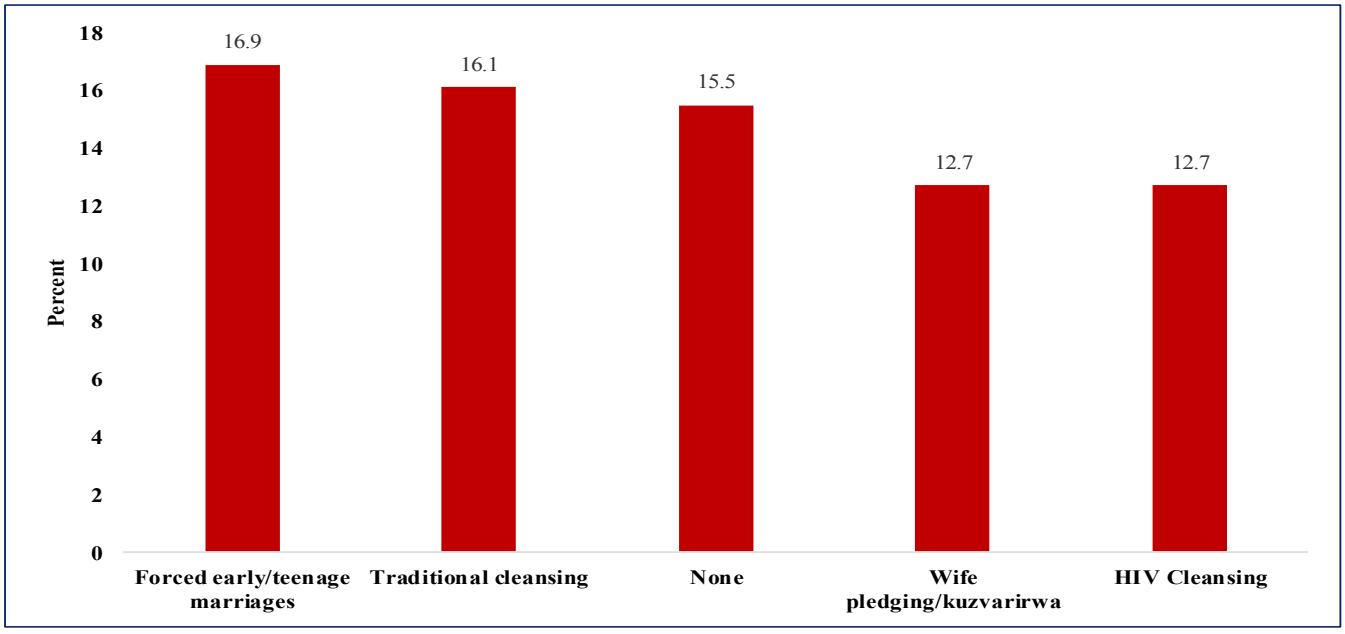

Religion was also cited as a driving factor of adolescent pregnancy in the FGDs, with most of them citing the Apostolic church as the major culprits. One of the adolescent girls had this to say:

Some men in these churches claim to have dreamt being married to you, they say "you were given to me in spirit" and you are forced to go to him (Rural Girl)

4.3.3.3. Socio-Cultural Factors

Adolescent girls were asked about cultural practices that put adolescent girls at risk of pregnancy in their communities. Figure 4.4 shows the cultural practices that put adolescent girls at risk of teenage pregnancy in their communities according to the ever pregnant adolescent girls aged 15-19. The cultural practices contributing to girls' risk of teenage pregnancy most cited were *forced early/teenage marriages* (17%) and *traditional cleansing* (16%).

Figure 4.4: Distribution of Adolescent Girls aged 15-19 Years ever been Pregnant by Cultural Practices that put Adolescents at Risk of Pregnancy



Cultural factors were also cited in the KIIs and FGDs. One of the key informants cited culture as a contributing factor to adolescent pregnancy:

… in farming areas such as Mash West, lots of Malawians settled as villagers after the land reform. Girls get pregnant around the time of "zvigure". They are impregnated whilst attending such functions. Girls don't see themselves as being abused and this is normalization of adolescent pregnancy, cycle of adolescent pregnancy. In maternity homes, you get girls aged 16 and 17 years mocking 21 year olds (Key Informant).

This was also mentioned in one of the FGDs for girls:




This season especially, we hold cultural dances in the evenings and that's when adolescent girls will meet with their lovers, one thing leads to another and eventually one becomes pregnant but if we could get our own spaces wherein we could discuss issues that affect us maybe it could help us (Rural Girl).

Other adolescent girls also commented on culture as a factor contributing to adolescent pregnancy:
When it comes to culture, our parents tell us that culture does not have laws that prohibit early marriages. So even a 14 year old can get married. Culture can be used when my sister fails to have a boy and my sister's husband is wealthy, the parents will push that I get married to the sister's husband because they would want to keep the 'lobola' that they were given. I can't deny because the 'lobola' has already been used so, so even if I am 14, I can be married off to my sisters' husband. Some might say this practice has ended because of the new laws we have, but this is still happening (Rural Girl).

There is also a case where a girl was offered to her sister's husband after her sister died before she had children. She had to flee to South Africa (Urban Girl).

4.3.3.4. Utilisation of Sexual and Reproductive Health Information and Services

Utilisation of sexual and reproductive health services is important in reducing teenage pregnancies and other SRH risks. Table 4.38 presents the distribution of the sexually experienced adolescent girls by utilisation of HIV prevention and family planning services. The main SRH services accessed by adolescent girls aged 10-19 years who have ever had sex were STI and HIV prevention (60%) and family planning (45%). Such services were mostly accessed at the clinic (49%) and through outreach programmes (39%). In relation to accessing the SRH services, 24% of adolescent girls aged 10-19 years who have ever had a sexual experience reported that it was difficult to access family planning services in their communities (13% very difficult and 11% somewhat difficult) while 15% reported that it was difficult to access condoms (9% very difficult and 6% somewhat difficult). Over two-thirds of adolescent girls (67%) who have ever had sex reported that there was no place that is friendly and comfortable for them to access SRH services in their community. A third of the adolescents reported that there was a friendly place and the friendly place most cited was the health facility (81%).

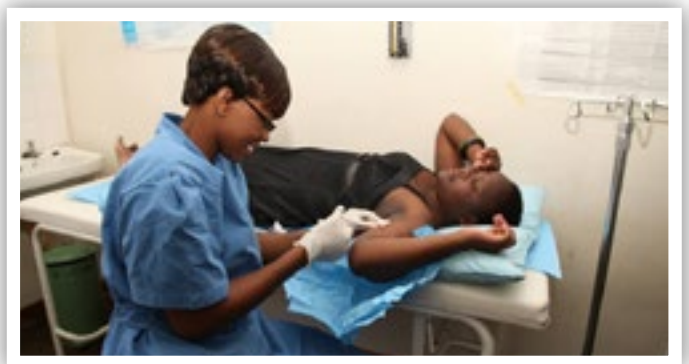






Table 4.38: Distribution of Adolescent Girls aged 10-19 Years who had Ever Had Sex by Access to Sexual and Reproductive Health Services and Age

	Age Group				Total 10-19	
	10-14		15-19			
	Number	%	Number	%	Number	%
Access to Sexual and Reproductive Health Services						
Family planning	1,813	25.3	90,620	45.8	92,434	45.0
STI and HIV prevention	2,842	39.6	118,316	59.7	121,158	59.0
Source of SRH Services						
Clinic	1,714	23.9	98,398	49.7	100,112	48.8
Outreach	180	23.8	6,338	39.9	6,518	39.2
Hospital	473	6.6	36,694	18.5	37,167	18.1
New Start Centre	0	0.0	2,552	16.1	2,552	15.4
Relative/Friend	368	48.7	2,069	13.0	2,437	14.7
Shops	0	0.0	1,946	12.3	1,946	11.7
Pharmacy	0	0.0	1,310	8.3	1,310	7.9
Private Doctor/Provider	208	27.5	940	5.9	1,148	6.9
Local community health worker	328	4.6	8,745	4.4	9,073	4.4
Other	0	0.0	711	4.5	711	4.3
Difficulty in Accessing FP Services						
Very difficult	691	9.6	25,303	12.8	25,994	12.7
Somewhat difficult	328	4.6	21,160	10.7	21,488	10.5
Not difficult at all	423	5.9	109,321	55.1	109,744	53.4
Don't know	5,731	79.9	42,504	21.4	48,235	23.5
Difficulty in Accessing Condoms						
Very difficult	332	4.6	17,842	9.0	18,174	8.8
Somewhat difficult	328	4.6	12,637	6.4	12,965	6.3
Not difficult at all	2,307	32.2	133,138	67.1	135,445	65.9
Don't know	4,206	58.6	34,673	17.5	38,878	18.9
Any Friendly Place to Access SRH services						
Yes	1,310	18.3	65,888	33.2	67,198	32.7
No	5,863	81.7	132,400	66.8	132,263	67.3
Friendly Place						
Health facility	1,065	81.3	53,232	80.8	54,297	80.8
Community-based worker	245	37.9	4,902	43.4	5,147	43.1
Church	0	0.0	2,633	23.3	2,633	22.1
Relatives/Neighbours place	402	62.1	1,856	16.4	2,258	18.9
Youth Centre	0	0.0	3,839	5.8	3,839	5.7
School	0	0.0	3,387	5.1	3,387	5.0
NGO	0	0.0	552	4.9	552	4.6
Business Centre	0	0.0	2,815	4.3	2,815	4.2
Other	0	0.0	1,345	11.9	1,345	11.3

Lack of access to SRH information and services was also identified in the FGDs as one




of the factors contributing to adolescent pregnancy. Instead, they get the information from unreliable and uncontrolled sources of information, such as the internet, social media, etc., which were reported as leading the children to experimenting and thus exposing themselves to risk of pregnancy. Access to pornography from the internet and television was identified as contributing to adolescent pregnancy, as reiterated by one member from a community FGD:

What they are viewing, on WhatsApp, on the internet, no one knows what they see, they can watch pornographic material, which are not even allowed, and because of what they view, they then want to experiment and see this usual thing that they are viewing every day. They say experience is the best teacher. (Urban Community FGD).

4.3.3.5. Utilisation of SRH Services during Delivery

Utilisation of SRH services during delivery is important for the survival of the young mother and the baby. Female adolescents reportedly do not use SRH services, and if they do, they delay seeking care for complications. Table 4.39 shows that 14% of the adolescent girls aged 15-19 years who had experienced a pregnancy delivered at home. However, the majority of the adolescents delivered at a health institution, 58% delivered at a hospital and 27% at the clinic. Most of the adolescents were attended to by a nurse or midwife on their first pregnancy during delivery (71%) and 12% by a doctor.

Table 4.39: Distribution of Adolescents aged 15-19 Ever Been Pregnant by Place of Delivery, Assistance during Delivery and Pregnancy Outcome

	Ever been Pregnant	
	Number	**%**
Place of Delivery		
Hospital	61,381	58.2
Clinic	28,029	26.6
Home	14,889	14.1
In transit to health facility	736	0.7
Other	516	0.5
Assistance at Delivery of First Pregnancy		
Nurse/midwife	77,202	71.1
Doctor	13,391	12.3
Traditional midwife	9,716	8.9
Relative	4,263	3.9
Self	1,529	1.4
Other	1,460	1.3
Don't know	1,043	1.0
Total	**108,604**	**100.0**

4.3.4. Community Level




4.3.4.1. Access to Media and ICT

Table 4.40 presents the distribution of adolescent girls aged 15-19 years by access to mass media and Information and Communication Technology (ICT). The majority of the adolescent girls aged 10-19 years did not read a newspaper at all (70%), 38% did not listen to the radio and 53% did not watch television. Less than a quarter of the adolescent girls aged 10-19 years (24%) owned a mobile phone and 9% ever used the Internet. Of those who had used the Internet, 89% had used the Internet in the last 12 months.

Table 4.40: Distribution of Adolescents aged 10-19 Years by Access to Mass Media, ICT and Age

	Age Group				Total 10-19	
	10-14		15 -19			
	Number	%	Number	%	Number	%
Frequency of reading a newspaper						
Almost everyday	15,354	2.0	18,191	2.3	33,545	2.1
At least once a week	75,612	9.8	114,112	14.3	189,724	12.1
Less than once a week	89,848	11.6	166,935	20.9	256,783	16.3
Not at all	594,246	76.7	499,592	62.5	1093,838	69.5
Frequency of listening to the radio						
Almost every day	194,079	25.0	242,977	30.4	437,056	27.8
At least once a week	179,844	23.2	158,177	19.8	338,021	21.5
Less than once a week	98,188	12.7	108,896	13.6	207,084	13.2
Not at all	302,949	39.1	288,780	36.2	591,729	37.6
Frequency of watching television						
Almost every day	173,081	22.3	233,539	29.2	406,620	25.8
At least once a week	103,873	13.4	89,347	11.2	193,220	12.3
Less than once a week	66,545	8.6	81,388	10.2	147,933	9.4
Not at all	431,562	55.7	394,555	49.4	826,117	52.5
Own a mobile phone						
Yes	44,008	5.7	333,708	41.8	377,716	24.0
No	731,053	94.3	465,122	58.2	1,196,174	76.0
Ever used the internet						
Yes	19,273	2.5	115,762	14.5	135,035	8.6
No	755,788	97.5	683,068	85.5	1,438,856	91.4
Total	**775,061**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100.0**
Used Internet during the last 12 months						
Yes	16,722	86.8	103,411	89.3	120,132	89.0
No	2,551	13.2	12,351	10.7	14,902	11.0
Frequency of Internet use during the last month						
Almost every day	3,662	19.0	39,154	33.8	42,816	31.7
Once a week	5,218	27.1	24,459	21.1	29,677	22.0
Once fortnightly	2,415	12.5	7,557	6.5	9,971	7.4
Once a month	2,740	14.2	15,611	13.5	18,350	13.6
Not at all	5,238	27.2	28,982	25.0	34,220	25.3
Total	**19,273**	**100.0**	**115,762**	**100.0**	**135,035**	**100.0**




Association between Adolescent Pregnancy and Access to Media and Internet

Table 4.41 shows the prevalence of adolescent pregnancy by access to the media and ICT among adolescents aged 15-19 years. Prevalence of adolescent pregnancy is higher among adolescent girls aged 15-19 years who never read the newspaper (22%) than those who read the newspaper almost every day (7%) ($p<0.001$). Adolescents who never listened to the radio were more likely to have been pregnant (19%) compared to those who listened to the radio at least once a week (14%) ($p<0.001$). Adolescent pregnancy was most prevalent among adolescent girls who had never watched television and who did not use the Internet in the last 12 months (22% and 14%, respectively) compared to those who watched television almost every day and who had used the Internet (9% and 8%, respectively) ($p<0.001$).

Table 4.41: Distribution of Adolescent Girls aged 15-19 Years by Ever been Pregnant and Access to Mass Media and the Internet

	Ever been Pregnant		P - value
	Number	%	
Frequency of Reading the Newspaper			
Almost everyday	1,261	6.9	<0.001
At least once a week	8,636	7.6	
Less than once a week	16,286	9.8	
Not at all	108,239	21.7	
Frequency of Listening to the Radio			
Almost every day	38,751	15.9	<0.001
At least once a week	22,771	14.4	
Less than once a week	17,897	16.4	
Not at all	55,002	19.0	
Frequency of Watching TV			
Almost every day	20,468	8.8	<0.001
At least once a week	13,776	15.4	
Less than once a week	12,302	15.1	
Not at all	87,876	22.3	
Ownership of a mobile phone			
Own a mobile phone	55,035	16.5	<0.001
Does not own a mobile phone	79,387	17.1	
Used the Internet in the last 12 months			
Used the Internet	7,905	7.6	<0.001
Did not use the Internet	1,707	13.8	




A further analysis was conducted on ever been pregnant by frequency of listening to the radio and watching television and household ownership of the radio and television. Table 4.42 shows that the adolescent girls whose households do not have a radio or television were at higher risk of pregnancy compared to those whose households had the radio and television.

Table 4.42: Distribution of Adolescent Girls aged 15-19 Years by Ever been Pregnant, Access and Ownership of a Radio and Television

	Ever been Pregnant					
	Household has a Radio			Household has no Radio		
	Number	%	P - value	Number	%	P - value
Frequency of Listening to the Radio						
Almost every day	34,435	15.7	<0.001	4,316	18.2	<0.001
At least once a week	15,519	12.7		7,252	20.2	
Less than once a week	11,307	15.1		6,590	19.3	
Not at all	12,211	14.2		42,791	21.1	
	Household has a TV			Household has no TV		
	Number	%	P - value	Number	%	P - value
Frequency of Watching Television						
Almost every day	19,141	8.5	<0.001	1,327	15.4	<0.001
At least once a week	8,673	12.8		5,103	23.8	
Less than once a week	6,960	14.5		5,343	16.1	
Not at all	9,384	21.3		78,491	22.4	

4.3.4.2. Sexual Abuse

Adolescent girls usually are vulnerable to sexual abuse. One way that leads to sexual encounter is the sexual harassment from the opposite sex. All adolescent girls aged 10-19 years were asked whether they had been touched in a way that they felt uncomfortable in the past 12 months. Table 4.43 shows that 8% of the adolescent girls aged 10-19 years reported *ever being touched in a way that they felt uncomfortable in the last 12 months,* 5% and 9% among girls aged 10-14 and 15-17 years, respectively. Nearly half of the girls (48%) who were touched in a way *they felt uncomfortable reported the incident to someone else*. Less than half of the adolescent girls aged 10-19 years who were touched in a way they felt comfortable reported the incident (49%) and most of these incidents were reported to the parents/caregivers (51%).



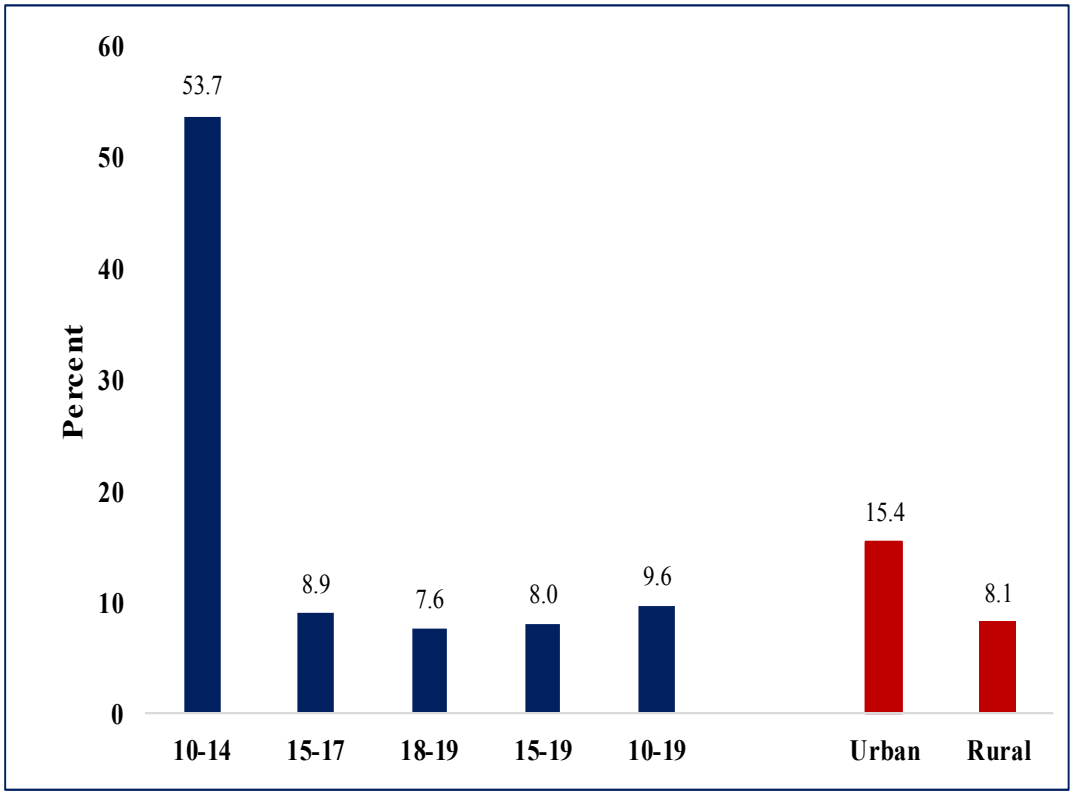

Table 4.43: Distribution of Adolescent Girls aged 10-19 Years by Confidence in Refusing Sex and Age

	Age Group								Total 10-19	
	10--14		15-17		18-19		15 -19			
	Number	%	Number	%	Number	%	Number	%	Number	%
Ever been touched in a way that you felt uncomfort-able in the past 12 months										
Yes	38,492	5.0	40,372	8.2	51,322	16.7	91,694	11.5	130,186	8.3
No	736,569	95.0	451,157	91.8	255,979	83.3	707,136	88.5	1,443,704	91.7
Total	**775,061**	**100.0**	**491,529**	**100.0**	**307,301**	**100.0**	**798,830**	**100.0**	**1,573,891**	**100.0**
Whether the inci-dent was reported										
Yes	26,447	68.7	20,919	51.8	15,823	30.8	36,742	40.1	63,189	48.5
No	12,045	31.3	19,453	48.2	35,498	69.2	54,952	59.9	66,997	51.5
Total	**38,492**	**100.0**	**40,372**	**100.0**	**51,322**	**100.0**	**91,694**	**100.0**	**130,186**	**100.0**
To whom it was Reported										
Parent/Caregiver or an adult from my family	16,003	60.5	9,367	44.8	6,652	42.0	16,017	43.6	32,021	50.7
Another adult I trust	2,317	8.8	5,105	24.4	4,505	28.5	9,611	26.2	11,927	18.9
Teacher	5,645	21.3	3,392	16.2	1,339	8.5	4,731	12.9	10,376	16.4
Friends	1,831	6.9	1,908	9.1	1,752	11.1	3,661	10.0	5,492	8.7
Someone else from my family (under 18 years old)	651	2.5	1,147	5.5	1,436	9.1	2,583	7.0	3,234	5.1
Boyfriend/girlfriend	0	0.0	0	0.0	139	0.9	139	0.4	139	0.2
Total	**26,447**	**100.0**	**20,919**	**100.0**	**15,823**	**100**	**36,742**	**100**	**63,189**	**100.0**

Respondents were asked the main reason for their first sexual encounter. Rape or forced sex was reported as one of the reasons of first sexual encounter by adolescent girls aged 15-19 years (10%). Adolescent girls aged 10-14 years were at higher risk of sexual abuse as 54% reported that they were raped or forced on their first sexual intercourse. The percentage of adolescent girls aged 10-19 years who were raped/forced on their first sexual encounter was higher in urban areas (15%) than in rural areas (8%). See Figure 4.5.




Figure 4.5: Distribution of the Sexually Experienced Adolescent Girls who were Raped/Forced on their First Sexual Encounter



Association between Adolescent Pregnancy and Sexual Abuse

Table 4.44 presents the association between adolescent pregnancy prevalence and whether one has been touched in a way that they felt uncomfortable. Adolescent girls aged 15-19 years who reported to have been touched in a way that they felt uncomfortable in the past 12 months were more likely to have ever been pregnant (22%) than those who were not touched (16%) (p<0.001). A similar association was found among adolescent girls aged 15-17 years (p<0.001).

WTable 4.44: Association between Adolescent Pregnancy and Sexual Experience

	Ever Been Pregnant						Total 15-19		
	Age Group								
	15-17			18-19					
	Number	%	P-Value	Number	%	P-Value	Number	%	P - value
Ever been touched in a way that you felt uncomfortable in the past 12 months									
Yes	3,689	9.1	<0.001	16,372	31.9	<0.001	20,061	21.9	<0.001
No	30,742	6.8		83,619	32.7		114,360	16.2	




4.3.4.3. Access to Information about Sexuality Issues

Access to SRH information by adolescents is important in order to reduce teenage and unintended pregnancies and other sexual reproductive health risks. All adolescent girls aged 10-19 years who participated in the survey were asked whether their parents or guardians had ever talked to them about issues related to sexuality. Table 4.45 shows that 57% of the adolescent girls aged 10-19 years had parents or guardians who talked to them about sexuality issues. Adolescent girls were also asked a question on whether their parents or guardians talked to them on selected topics on sex and reproductive health issues. Sexuality issues most discussed with their parents/guardians were: *reasons why they should not have sex at their age* (60%) and *menstruation* (55%) and less on pregnancy (9%).

Table 4.45: Distribution of Adolescent Girls by Discussion on Sexuality Issues with Parents/Guardians and Age Group

	Age Group								Total 10-19	
	10-14		15-17		18-19		15-19			
	Number	%	Number	%	Number	%	Number	%	Number	%
Parents/guardians ever talked to them about issues related to sexuality										
Parents/guardians talked to them	359,994	46.4	327,686	66.7	209,122	68.1	536,809	67.2	896,802	57.0
Parents/guardians did not talk to them	415,067	53.6	163,843	33.3	98,178	31.9	262,021	32.8	677,088	43.0
Issues Discussed										
Reasons why you should not have sex at your age	375799	48.5	337,719	68.7	218,659	71.2	556,378	69.6	932,177	59.2
Menstruation	301755	38.9	346740	70.5	220463	71.7	567202	71.0	868,957	55.2
STIs, including HIV	275,404	35.5	299,247	60.9	201,909	65.7	501,156	62.7	776,560	49.3
Abstinence	15,437	55.4	13,268	43.1	8,263	38.1	21,531	41.0	36,968	46.0
Relationships	5,771	20.7	4,690	15.2	3,548	16.3	8,237	15.7	14,008	17.4
Early Marriages	2,319	8.3	4,114	13.4	2,879	13.3	6,993	13.3	9,312	11.6
Pregnancy	1,375	4.9	3,302	10.7	2,344	10.8	5,646	10.8	7,021	8.7
HIV, AIDS & STIs & Cancer	1,278	4.6	2,008	6.5	3,327	15.3	5,335	10.2	6,613	8.2
Pre-marital sex	0	0.0	2,402	7.8	869	4.0	3,271	6.2	3,271	4.1
Menstrual hygiene	1,703	6.1	987	3.2	477	2.2	1,464	2.8	3,167	3.9

Association between Adolescent Pregnancy and Discussion of Sexuality issues

Adolescent girls aged 15-19 years whose parents or guardians had never talked to them about sexuality issues were more likely to have been pregnant (20%) compared to their counterparts whose parents/guardians had talked to them (15%) ($p<0.001$). See Table 4.46.




Table 4.46: Association between Adolescent Pregnancy and Ever been Pregnant and Sexuality Issues Discussed among Adolescent Girls aged 15-19 Years

	Ever Been Pregnant		
	Number	%	P - value
Whether parents/ guardians ever talked to them about sexuality issues			
Parents/guardians talked to them	82,739	15.4	<0.001
Parents/guardians did not talk to them	51,682	19.7	
Total	**134,422**	**16.8**	

4.3.5. National Level

Data at national level was mostly obtained from the desk review and key informant interviews. The policies and legislations, strategic plans and programmes related to adolescent sexual and reproductive health are presented in this section.

4.3.5.1. Policies and Legislations Addressing Adolescent Reproductive Health

The Constitution of Zimbabwe Amendment (No. 20) Act, 2013

The new Constitution of Zimbabwe guarantees the right to health, including reproductive health to all citizens. It contains a Declaration of Rights that seeks to protect "the fundamental rights of the individual", but not specifically of adolescents. Section 78(1) of the Constitution of the Republic of Zimbabwe Amendment Number 20 of 2013 sets 18 years as the minimum age of marriage in Zimbabwe. Section 26 of the Constitution provides that no marriage must be entered into without the free and full consent of the intending spouses. This means that forced marriages and child marriages are prohibited under the Constitution and that children must not be pledged into marriage.

The National Population Policy

The National Population Policy of 1988 recognises women's right to control their fertility[69]. The Population Policy specifies that "individual rights to choose freely and responsibly the number, spacing and timing of children they want will be fully respected" and that it is essential to recognise the aspirations of women and youth in particular. The policy specifically states the need to address adolescent health, with particular emphasis on reproductive health[70]. The Population Policy includes a goal related to adolescents, i.e., to "reduce prevalence of high risk sexual behaviour among the youth"[70]. One of the targets related to the youth is to "reduce the proportion of adolescents who are becoming mothers below the age of 20 from 40% in 1994 to a lower figure by the year 2002"[70]. However, the Population Policy has never been implemented. The policy was revised in 2009 and has again was shelved up to the present.

The Marriage Act

The Marriage Act (Chapter 5:11), previously allowed a girl to marry at age 16, but this was outlawed in January 2016. According to the January 2016 ruling, the age of




marriage is now 18 years. The focus on the Act is on marriage, but children are having sexual intercourse outside marriage. The age of consent still remains at 16 years and there is a possibility of an increase in childbearing outside marriage as the men try to avoid prosecution by rejecting the responsibility of the pregnancy. Therefore, there is need for alignment of policies on marriage and age of consent. Also, many cases of child marriage go unreported, especially in rural areas.

Age of Consent

The age of consent in Zimbabwe is 16 years, i.e. the minimum age at which an individual is considered legally old enough to consent to sexual activity. Sexual engagement with persons aged below 16 years results in prosecution for statutory rape or the equivalent local law. However, most cases of rape go unreported, especially if the perpetrator is a relative. There is also lack of harmonisation of policies. Age of marriage was recently moved to 18 years while age of consent is 16 years.

The Legal Age of Majority Act

The Legal Age of Majority is 18 years. This gives those 18 years and above the contractual capacity to enter or to act without the consent of a guardian. Thus, the law implies that, in relation to access to SRH services, adolescents can obtain such services without parental involvement. However, in reality adolescents' access to SRH services faces a challenge as health service providers have been reported to deny adolescents to SRH services, such as contraceptives[69]. This challenge as also mentioned by the key informants. Also, access to information on contraceptives is also not available in schools.

The Sexual Offences Act

Sexual intercourse with a girl who is younger than 16 is a crime of statutory rape which is governed by the Sexual Offences Act. It is a crime for anyone over 15 years of age to have sexual intercourse with a 'young person', i.e. anyone under the age of 16 years[69]. It is a crime even if she agreed to have sex. The law in this regard has been made to protect girls because, at that age even if they consent, they are not old enough to fully realize what it will mean in their lives if they have a sexual relationship[69]. However, age of sexual consent is 16 years while age of marriage is 18 years. There is need for harmonisation of the laws.

Ministry of Primary and Secondary Education School Health Policy

The objective of the Health Policy is to ensure that children are empowered by being taught SRH at an early age so that knowledge can translate into behaviour. However, the challenge is that schools promote abstinence among pupils, hence assuming no access to SRH services, yet these adolescents are engaging in sexual activity. In addition, school-based interventions often miss out-of-school youths who occupy a significant proportion of the adolescent population.

School's Re-entry Policy

The School's Re-entry policy objective is to allow re-entry of pregnant girls into school




after delivery. The regulation allows three months maternity leave for pregnant school girls. However, the policy has not been that effective due to several reasons. There is no political will to make it happen as the Policy is not being popularized. The policy does not allow a girl to go back to the same school, thus the school might be further from home, thus making it difficult for a nursing mother to go back into class. The girls who return to school are also limited socially because of stigmatization of single mothers.

The 2015 National Non-Formal Education Policy for Zimbabwe

The National Non–Formal Education (NFE) Policy is aimed at providing basic education to all. This policy originates from the Universal Declaration of Human Rights (UDHR) which recognises compulsory education as a universal entitlement and the Convention on the Rights of the Child (1989) which affirms the right of all children to free and compulsory primary education (Article 28.1.a). The NFE Policy reflects the Ministry's commitment to improving access to education and ensuring equitable quality service delivery. This policy caters for the education of the adolescent mothers who may find it difficult to go back into formal education.

Zimbabwe National Youth Policy

The broad objective of the policy is to empower the youth. One of the policy goals related to adolescent SRH is to "promote healthy lifestyles and personal well-being with particular emphasis on prevention of HIV/AIDS and promotion of reproductive health and care". However, there is no political commitment to make the policy effective.

National Orphan Care Policy

The goal of the policy is to develop national institutional capacity to identify all orphans and other vulnerable children and to reach out service provision to at least 25% of OVC in Zimbabwe. While the policy prioritizes OVC to be raised within a family set up, the challenge is that many families are resource-poor, and the breakdown of extended family ties makes it particularly difficult for double orphans to be re-integrated with their extended families. This results in most OVCs being institutionalized. Some of the orphans become victims of sexual abuse by the people who are supposed to be looking after them.

4.3.5.2. Strategic Plans and Programmes

Ministry of Primary and Secondary Education Life Skills, Sexuality, HIV and AIDS Strategic Plan 2012-2015

The objective of the strategic plan is to ensure that the education sector supports all learners with access to correct information and skills related to SRH, HIV prevention, care, treatment and support by end of 2015. The life skills education programme promotes abstinence, yet children are engaging in sex. SRH education not comprehensive, the programme has largely ignored issues of gender and sexuality. The Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) project findings showed that teachers have knowledge about SRH and HIV but lack skills to impart the knowledge.




Adolescent Sexual Reproductive Health Strategy (2010-2015)

The strategy refers to access to age-appropriate SRH services by adolescents. The strategy is effective as it addresses the youth problems at youth-friendly corners. The challenges faced in implementing the strategy include poor funding, limited services to areas hard to reach, inadequate resources - human and material, and socio-cultural norms and values.

National Adolescent Sexual and Reproductive Health (ASRH) Advocacy Package and Implementation Plan: 2014 – 2015 for Zimbabwe

One of the specific objectives of the ASRH Advocacy Package is to create a safe and supportive environment for addressing SRH issues for young people with a key intervention area of policy and advocacy. The main challenge faced when implementing the plan is the conflicting values as a mother, a Christian and as a programmer/health provider. Staff in health institutions are reluctant to serve children with contraceptives.

National Action Plan for Orphans and Vulnerable Children (NAP for OVC) Phase II, 2011-2015

The Plan aims to increase access of all vulnerable children to effective child protection services and basic education, health and other services. The Basic Education Assistance Module (BEAM) is one such programme that assists orphans and vulnerable children with payment of school fees to keep them in school. The programme is overwhelmed by the number of OVCs that need assistance. Thus, not all OVCs receive this assistance. The biggest challenge faced in implementation of the NAP for OVC is the limited resources. The programme is largely driven by donors than by government.

National Adolescent Sexual and Reproductive Health (ASRH) Advocacy Package and Implementation Plan: 2014 – 2015

One of the specific objectives of the plan is to create a safe and supportive environment for addressing SRH issues for young people. The Advocacy Package mandate is central in influencing public opinion, policy makers, community and national leaders who are also key to mobilizing resources and political commitment necessary to advocate for ASRH. However, there is lack of multi-sectoral collaboration as each ministry is doing its own thing.

The Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe

The protocol is to guide all who work with abuse - supporting the abused. The protocol allows for termination of pregnancy in the event of pregnancy after sexual abuse. This is done after authority is granted by a magistrate. However, the termination of pregnancies for special cases is not handled on time. The process in the justice system takes long and pregnancies may reach delivery before the case is held.

Sista2Sista Programmes/Girls only clubs - 10-19 years

The Sista2Sista club is a girls' empowerment programme run by several NGOs, supported by UNFPA, National AIDS Council (NAC) and other partners. The club offers a safe place to




vulnerable adolescent girls where they share their experiences with mentors and each other. The girls are taught about sexual and reproductive health and rights, financial literacy and how to address difficult social situations. The programme's objective is to give girls the confidence and self-esteem to stand up for themselves. They are taught that earl marriage is wrong and to report cases of sexual abuse. Evidence has shown that girls-only clubs are effective as fewer pregnancies and marriages are found among girls who are in these clubs.

4.3.5.3. Policy Implementation and Enforcement

The Government of Zimbabwe leads in formulating policies and laws related to adolescent sexual and reproductive health. However, the implementation and enforcement of the policies was by the key informants to be weak. It was noted that public health providers rigorously enforce parental requirements. Health workers were reported by some key informants not to provide adolescents under the age of 18 years with services and information on contraception and STI prevention without parental consent. These health providers also inform parents when the children come for such services. The Ministry of Primary and Secondary Education is opposed to providing condoms in schools and the Minister stated that the Government does not intend to give condoms in schools but urged parents who were concerned about their children's sexual activities to do so[71]. The parents and churches are also opposed to proving schoolchildren with condoms. Lack of financial resources has also affected the implementation of some the policies and strategies. Lack of coordination of the programme among the different ministries was also cited as a major problem. Each ministry was reported to be running its own programmes. Some socio-cultural norms and values play a part in breaking the laws, and result in some families protecting the perpetrators of sexual abuse and rape, especially if the perpetrator is a relative.

4.3.6. Perceptions on the Causes of Adolescent Pregnancy

Figure 4.6 gives a summary of the causes of adolescent pregnancy cited in the FGDs among boys and girls. The most cited causes of adolescent pregnancy were the church and poverty/ lack of money. Among FGDs for girls, dressing and rape appear to have been cited by many groups while on the boys' side girls, the Marange Apostolic church and peer pressure featured more.

Figure 4.6: Summary of the Perceptions on Causes of Adolescent Pregnancy from FGDS among Boys and Girls




Table 4.47 also presents the causes of adolescent pregnancy mentioned by key informants at sub- and national level. At personal level, causes cited include lack of money and poverty, also mentioned in the FGDs.

Table 4.47: Perceptions on the Causes of Adolescent Pregnancy

LEVEL	CAUSES OF ADOLESCENT PREGNANCY
Individual	Lack of knowledge Substance abuse Unemployment Child marriages
Interpersonal	Poverty Peer pressure, Child headed families Absent parents Erosion of extended families Poor parental guidance Parents sleeping in the same room as adolescents, they become sexually aware at early age
Community	Sexual abuse Social media 'Vuzu'/pool parties Lack of recreational facilities Talking about sex a taboo Girls taught to be submissive Brother-in-law playing with sister-in-law ('ukulamuza''chiramu').
Organisational	Churches that allow/promote child marriages Attitude of health workers Wife pledging
National	Legal age of consent Unhealthy social security

4.4. Factors Contributing to Adolescent Pregnancy - Logistic Regression Analysis

Logistic regression was conducted to determine the factors contributing to adolescent pregnancy important for programmers to focus on. These were done at different levels (individual, inter-personal, organisational, community and national).

4.4.1. Individual Level

The key factors contributing to adolescent pregnancy include age, marital status, alcohol use, self-efficacy/confidence in refusing sex, contraceptive use, knowledge of pregnancy, knowledge of contraceptives, and attitudes towards sexuality issues. Table 4.48 presents the factors that were found to be significantly associated with adolescent pregnancy. Age was found to be a contributing factor to adolescent pregnancy. As age increased adolescents were more likely to be at risk of pregnancy. Adolescents aged 19 years were 1.45 times more likely to get pregnant compared to adolescents aged 15 years. Married adolescents have 1.2 times greater odds of becoming pregnant compared to the divorced/separated/widowed. Adolescents who were under the influence of alcohol during their first sexual encounter were less likely to become




pregnant compared to those who were not under the influence of alcohol. Those who had no confidence in refusing sex were 1.1 times more likely to have been pregnant compared to those who had confidence. Adolescents who used contraceptives during their first sexual encounter were less likely to get pregnant compared to those who did not use contraceptives. Adolescents with no comprehensive knowledge on pregnancy were 2.65 likely to get pregnant compared to the adolescent who have comprehensive knowledge. Adolescents with a positive attitude towards sexuality issues were less likely to get pregnant compared to those with a negative attitude.

Table 4.48: Factors Contributing to Adolescent Pregnancy at Individual Level

Variables in the Equation Step 1a	Exp(B) OR	95.0% C.I. for EXP(B)-OR Lower	 Upper	 Sig.
Age at Last birthday				
Continuous Years	1.45	1.43	1.46	<0.001
Marital Status (Ref. = Separated/Divorced)				
Never married	0.18	0.17	0.19	<0.001
Married	1.20	1.14	1.27	<0.001
Under Influence of Alcohol (Ref. = No)				
Yes	0.585	0.566	0.604	<0.001
Don't know	0.465	0.441	0.490	<0.001
Confidence in refusing Sex (Ref. = Confidence)				
No confidence	1.09	1.06	1.12	<0.001
Use of contraceptives during first sexual experience (Ref. = No)				
Yes	0.40	0.39	0.41	<0.001
Knowledge on Pregnancy (Ref. = Comprehensive knowledge)				
No Comprehensive Knowledge	2.68	2.56	2.81	<0.001
Attitude towards Pregnancy, Condoms and Sexuality Issues (Ref. = Negative)				
Positive	0.38	0.37	0.39	<0.001

4.4.2. Interpersonal Level

Table 4.49 presents the contributing factors significantly associated with adolescent pregnancy at interpersonal level. Adolescent pregnancy is associated with wealth quintile. Adolescents from households in the second, middle and fourth wealth quintile were at greater odds of becoming pregnant compared to adolescents from households in the highest wealth quintile, with the adolescents from households in the middle wealth quintile having the greatest risk of pregnancy. Orphans were more likely to become pregnant compared to non-orphans, with double orphans having the greatest odds of becoming pregnant compared to the other orphans. Adolescents who received pressure from friends to get pregnant were less likely to get pregnant compared to those who did not receive pressure. Adolescents who received pressure from relatives to get pregnant were 1.2 times more likely to get pregnant compared to those who did not receive pressure. Adolescents who have sisters who became pregnant before the




age of 20 years were 1.45 times more likely to have been pregnant compared to those with sisters who did get pregnant. Similarly, adolescents who have friends who became pregnant before the age of 20 years were 1.4 times more likely to become pregnant compared to those did not have friends who got pregnant.

Table 4.49: Factors Contributing to Adolescent Pregnancy at Interpersonal Level

Independent Variables	Exp(B) OR	95.0% C.I. for EXP(B)-OR		Sig.
		Lower	Upper	
Wealth Quintile (Ref. = Highest)				
Lowest	0.29	0.29	0.30	<0.001
Second	1.10	1.07	1.12	<0.001
Middle	1.61	1.59	1.64	<0.001
Fourth	1.22	1.20	1.24	<0.001
Orphanhood Status (Ref. = Non-orphan)				
Maternal Orphan	1.37	1.33	1.40	<0.001
Paternal Orphan	1.48	1.45	1.50	<0.001
Double Orphan	1.71	1.68	1.74	<0.001
Received any pressure from friends to get pregnant (Ref. = No)				
Yes	0.64	0.62	0.66	<0.001
Receive(d) any pressure from relatives to get pregnant (Ref. = No)				
Yes	1.22	1.18	1.27	<0.001
Have a sister(s) who became pregnant before the age of 20 years (Ref. = No)				
Yes	1.45	1.431	1.468	<0.001
Don't know	1.78	1.693	1.872	<0.001
Have any friends who became pregnant before the age of 20 years (Ref. = No)				
Yes	1.37	1.35	1.38	<0.001
Parents/guardians ever talked to you about issues related to sexuality (Ref. = No)				
Yes	0.81	0.80	0.82	<0.001

4.4.3. Organisational Level

Table 4.50 presents the factors contributing to adolescent pregnancy at organisational level. Adolescents residing in rural areas were 1.8 times more likely to get pregnant compared to adolescents residing in urban areas. Adolescents residing outside Harare were at higher odds of getting pregnant compared to those residing in Harare, with adolescents residing in Matabeleland North and Matabeleland South having the greatest risk. Adolescents belonging to the Tonga ethnic group were 1.6 times more likely to have been pregnant compared to the Zezuru while the Karanga were less likely to have been pregnant compared to the Zezuru.




Adolescents belonging to the Apostolic Sect were 1.3 times more likely to become pregnant compared to those who belonged to the traditional church while those not belonging to any church were 1.7 times more likely to have been pregnant. Frequent church goers (who attended church once a week) were less likely to be at risk of pregnancy compared to those who attended a few times a year.

Table 4.50: Factors Contributing to Adolescent Pregnancy at Organisational Level

Variables in the Equation Step 1a	Exp(B) OR	95.0% C.I. for EXP(B)-OR		
		Lower	Upper	Sig.
Residence (Ref. = Urban)				
Rural	1.75	1.63	1.87	<0.001
Province (Ref. = Harare)				
Bulawayo	1.45	1.36	1.54	<0.001
Manicaland	1.24	1.15	1.35	<0.001
Mashonaland Central	1.37	1.25	1.49	<0.001
Mashonaland East	1.15	1.05	1.25	0.003
Mashonaland West	1.82	1.67	1.98	<0.001
Matabeleland North	2.78	2.52	3.06	<0.001
Matabeleland South	2.13	1.93	2.34	<0.001
Midlands	1.08	0.99	1.17	0.092
Masvingo	0.80	0.72	0.87	<0.001
Ethnicity (Ref. = Zezuru)				
Karanga	0.708	0.695	0.72	<0.001
Korekore	1.217	1.193	1.242	<0.001
Manyika	1.199	1.171	1.228	<0.001
Ndebele	1.373	1.349	1.397	<0.001
Tonga	1.558	1.496	1.624	<0.001
Kalanga	1.297	1.226	1.371	<0.001
Ndau	1.276	1.245	1.307	<0.001
Other	0.980	0.950	1.011	0.211
Foreigner	1.486	1.450	1.524	<0.001
Don't know	0.385	0.367	0.405	<0.001
Religion (Ref. = African Traditional)				
None	1.682	1.589	1.781	<0.001
Catholic	1.043	0.979	1.111	0.197
Protestant/Pentecostal	1.042	0.983	1.106	0.166
Other Christian	1.091	1.026	1.160	0.006
Apostolic sect	1.314	1.241	1.392	<0.001
Islam	2.669	2.444	2.914	<0.001
Religiosity (Ref. = A few times a year)				
Once a week	0.75	0.73	0.77	<0.001
More than once a week	0.83	0.81	0.86	<0.001
A few times a month	0.84	0.82	0.87	<0.001




4.4.4. Community Level

Adolescents who read a newspaper at least once a month were less likely to be at risk of pregnancy compared to those who read a few times a year, with those who read once a week having the least odds. Adolescents who listened to the radio almost every day were 1.1 times more likely to have been pregnant compared to those did not listen to the radio. However, adolescents watching TV were less likely to become pregnant compared to those that did not watch while those who ever used the Internet were 1.7 times more likely to get pregnant compared to those who never used the Internet. Adolescents who had been touched in a way they felt uncomfortable were 1.6 times more likely to get pregnant compared to those that were not touched. See Table 4.51.

Table 4.51: Factors Contributing to Adolescent Pregnancy at Community Level

Variables	Exp(B) OR	95.0% C.I. for EXP(B) Lower	Upper	Sig.
Frequency of Reading a Newspaper (Ref. = Not at all)				
Almost everyday	0.26	0.25	0.28	<0.001
At least once a week	0.39	0.38	0.40	<0.001
Less than once a week	0.45	0.45	0.46	<0.001
Frequency of listening to a Radio (Ref. = Not at all)				
Almost everyday	1.11	1.09	1.13	<0.001
At least once a week	0.89	0.88	0.91	<0.001
Less than once a week	1.08	1.05	1.10	<0.001
Frequency of Watching TV (Ref. = Not at all)				
Almost everyday	0.45	0.44	0.46	<0.001
At least once a week	0.78	0.76	0.80	<0.001
Less than once a week	0.67	0.65	0.68	<0.001
Ever Used an Internet (Ref. = No)				
Yes	1.65	1.63	1.67	<0.001
Own a Mobile Phone (Ref. = No)				
Yes	0.71	0.70	0.73	<0.001
Ever been touched in a way that you felt uncomfortable in the past 12 months (Ref. = No)				
Yes	1.53	1.50	1.56	<0.001

4.5. Consequences of Adolescent Pregnancy

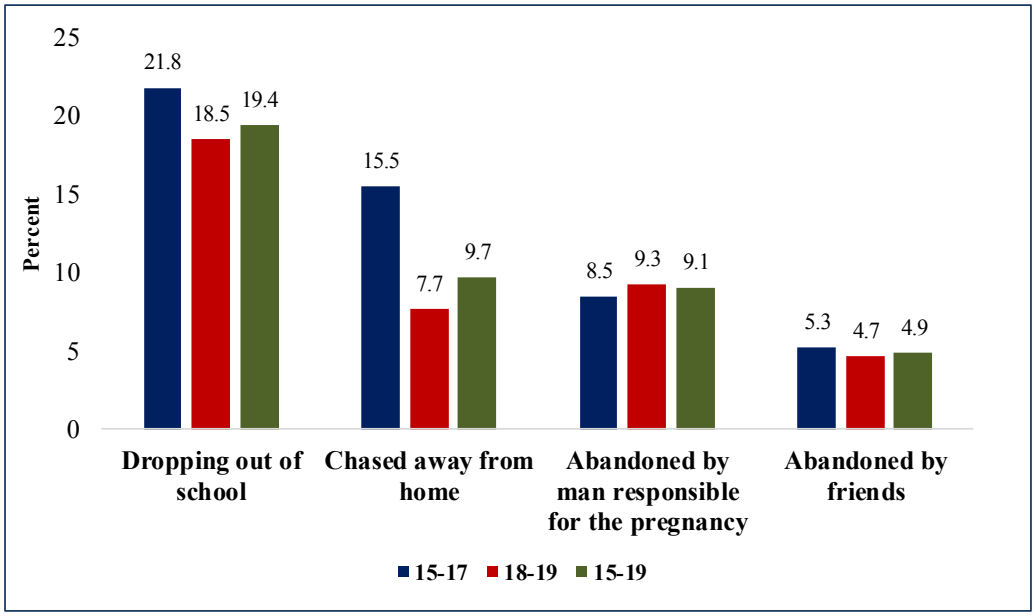
4.5.1. Socio-Economic Consequences

Adolescent girls aged 15-19 years who had ever been pregnant were asked what action was taken on their first pregnancy. Figure 4.7 shows that the impact of pregnancy was felt on education as 19% dropped out of school as a result of the pregnancy, higher among adolescent girls aged 15-17 years (22%) compared with those aged 18-19 years (19%). Other consequences of adolescent



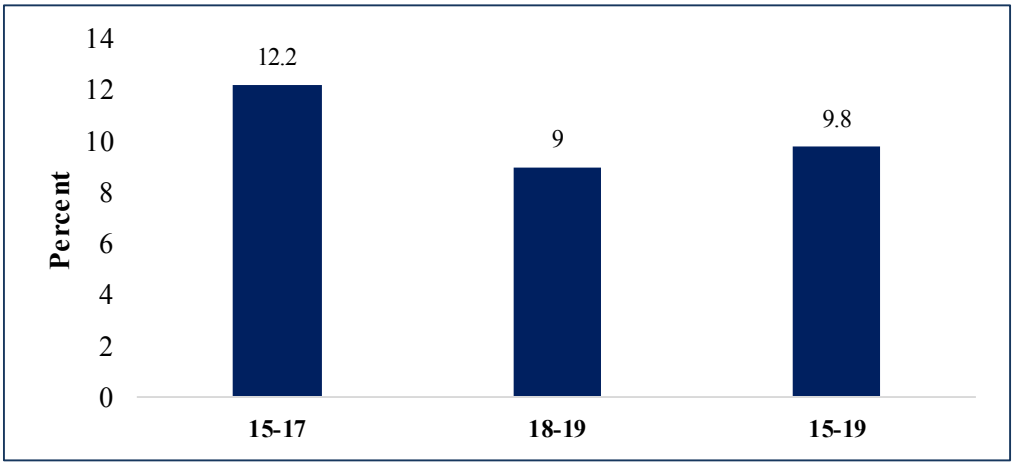

pregnancy were chased away from home (10%), abandoned by the man responsible for the pregnancy (9%) and abandoned by friends (5%).

Figure 4.7: Distribution of Adolescents aged 15-19 Ever Been Pregnant by Action Taken on First Pregnancy



The consequence of abandonment by the man responsible for the pregnancy was also found on the question on whether the man responsible for the first pregnancy accepted responsibility. A tenth of the ever pregnant adolescent girls aged 15-19 years reported that their partners responsible for their first pregnancy did not accept responsibility, with younger girls aged 15-17 years at higher risk of being rejected (12%) compared with their older counterparts aged 18-19 years (9%). See Figure 4.8.

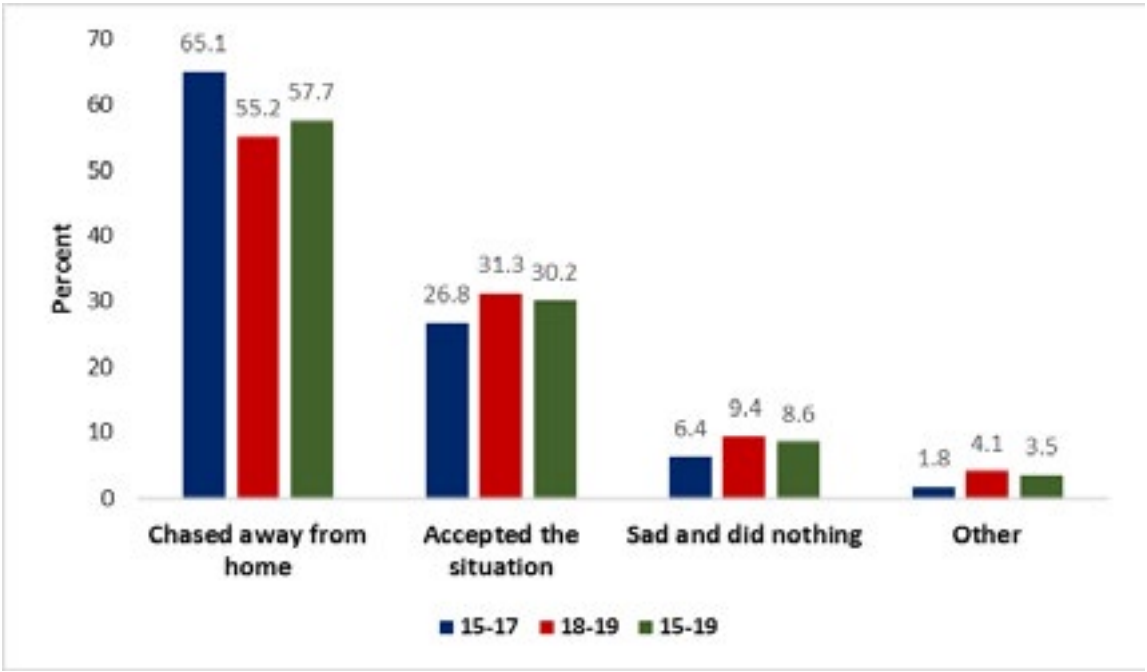
Figure 4.8: Distribution of Adolescent Girls whose Partner Responsible for their First Pregnancy did not Accept Responsibility by Age






Respondents who had ever been pregnant were also asked about their parents'/guardians' reaction to the pregnancy. Figure 4.9 shows that 58% of the adolescents aged 15-19 who had ever been pregnant were chased away from home when they became pregnant while 30% of the adolescents' parents and guardians accepted the situation. The proportion of adolescents chased away from home was higher among younger girls aged 15-17 years compared to the older ones aged 18-19 years.

Figure 4.9: Percent Distribution of Adolescents aged 15-19 who had Ever Been Pregnant by Parents/ Guardians' Reaction to Pregnancy, N=4039



The socio-economic consequences identified from the FGDs and key informant interviews included the following: poverty, expulsion from school, dropping out of school, disturbance of education, stigmatization of single mothers, depression, low self-esteem, prone to abuse, promiscuity, stress and suicide. Some of the comments that came from the key informants and FGDs include the following:

Pregnancy disturbs schooling. They are unlikely to proceed with schooling, and thus are not empowered, and as a result leading to a cycle of poverty. Because they are less educated and it would be difficult to get better-paying jobs, they become more vulnerable adults and are prone to sexual abuse/ gender violence (Key Informant).

Lack of progress of personal development in the girls' lives. These girls end up being maids, cross border traders, seated at home and housewives looking after their husbands (Key Informant).




Socially, girls are limited - stigmatization of single mothers. Some of the peers/friends may say "ndaakutorerwa murume" (my husband is being taken away) because she is not married. Referred to as 'mvana' (single mother) (Key Informant).

When my friend fell pregnant, her parents sent her away saying she has to be on her own despite the fact that she had nothing she owned herself. She was forced into prostitution in order to be able to look after her child (Urban Girl).

Those girls who fall pregnant in this community avoid going outdoors. They will stay indoors and when they are almost due that is when they show themselves to the world or to they will show themselves after giving birth....you we just hear that she now has a baby (Rural Girl).

4.5.2. Health Consequences

Adolescent girls who had ever been pregnant were asked about the outcome of the first pregnancy. Eleven percent of the ever pregnant adolescent girls aged 15-19 years reported that their first pregnancy did not end in a live birth (still birth or miscarriage/abortion), 17% among adolescent girls aged 15-17 years and 9% among those aged 18-19 years. This shows that younger girls aged 15-17 are more vulnerable to negative adolescent pregnancy outcomes than the older adolescents aged 18-19 years. See Table 4.52.

Table 4.52: Distribution of Adolescents aged 15-19 Ever Been Pregnant by Pregnancy Outcome and Age

Pregnancy Outcome	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Live birth	20,305	82.8	80,003	90.7	100,308	89.0
Still birth	837	3.4	2,079	2.4	2,915	2.6
Miscarriage/Abortion	3,370	13.7	6,162	7.0	9,533	8.5
Total	**24,512**	**100.0**	**88,244**	**100.0**	**112,756**	**100.0**

Most of the health consequences of adolescent pregnancy emerged from the FGDs and key informant interviews. Health consequences most likely to be faced by the mother that were cited were complications during pregnancy and delivery *(obstetric fistula, obstructed labour, uterine rupture*), *maternal morbidity and mortality, cervical cancer, and abortions*. Health consequences to the baby cited were *still births*, *pre-term babies, malnourished babies, low birth weight*, and *malnutrition, child morbidity and mortality*.

Abortions are experienced as teenage girls try to end pregnancy, which are unsafe in countries where abortion is illegal. Adolescent girls aged 10-19 years were asked on the ways they have heard that are used by girls of their age to try to end pregnancy. The ways to end pregnancy most cited were herbal drinks or food (40%), eating or drinking something other than herbs (26%) and tablets/pills (23%). (See Table 4.53).




Table 4.53: Distribution of Adolescent Girls aged 10-19 Years by Ways Used by Adolescents to Try to End Pregnancy and Age

Ways Used to End Pregnancy	Age Group				Total (n = 1573890)	
	10--14 (n = 775061)		15-19 (n=798829)			
	Number	%	Number	%	Number	%
Herbal drinks or food	227404	29.3	404781	50.7	632186	40.2
Eating or drinking something (other than herbs)	128270	16.5	284349	35.6	412619	26.2
Tablets/pills	130011	16.8	232363	29.1	362374	23.0
Surgical abortion	44472	6.4	99107	12.4	143579	9.1
Use sharp objects	25837	3.3	62383	7.8	88220	5.6
Lifting heavy objects	15567	2.0	15836	2.0	31403	2.0
Massage	5863	0.8	6765	0.8	12628	0.8
Jumping/falling	4314	0.6	5143	0.6	9457	0.6

The ways to end pregnancy were also echoed in the FGDs with girls.

Parents don't accept girls getting pregnant before they get married, and sometimes they will chase their daughter away ….. they will be saying we told you but you did not listen. So many girls just go to nángas (traditional healers) or drink surf (washing powder) to get rid of the pregnancy because they will be afraid to be chased away from home, especially if the person responsible for the pregnancy is unwilling to accept responsibility (Urban Girl).

We have heard that drinking aloe vera terminates pregnancy, so some of the girls who fall pregnant drink it (Rural Girl).

Some say you use a hanger after sex and you don't get pregnant. Boiled coke as well, because we are told it is poisonous so it will kill the baby (Urban Girl).

Respondents were asked where girls of their age would seek care when they have had a complication trying to end pregnancy. The majority of the adolescent girls aged 10-19 years (65%) reported that the girl would go to a health facility. More than half of the adolescent girls (52%) said that an unmarried girl would be reported to the police if she went to a public health facility to seek treatment for complications after trying to end a pregnancy. See Table 4.54.




Table 4.54: Place to Seek Care when an Adolescent has Complications from Trying to End a Pregnancy

	Age Group				Total 10-19	
	10-14		15-19			
	Number	%	Number	%	Number	%
Place where to go to seek care						
Health Facility	488,235	63.0	2,729	63.8	1,024,241	65.1
Traditional healer	39,040	5.0	62,095	7.8	101,135	6.4
Wait/don't seek care	14,454	1.9	38,144	4.8	52,598	3.3
Private provider	14,911	1.9	31,329	3.9	46,240	2.9
Pharmacist	590	0.1	2,827	0.4	3,417	0.2
Other	31,208	4.0	39,547	5.0	70,755	4.5
Don't know	186,623	24.1	88,882	11.1	275,505	17.5
Whether an unmarried girl will be reported to the police if she went to a public health facility to seek treatment for complications after trying to end a pregnancy						
Yes	345,782	44.6	468,525	58.7	814,307	51.7
Maybe	73,530	9.5	81,456	10.2	154,986	9.8
No	138,336	17.8	142,799	17.9	281,135	17.9
Don't know	217,412	28.1	106,050	13.3	323,462	20.6
Total	**775,060**	**100.0**	**798,830**	**100.0**	**1,573,890**	**100.0**




5. Discussion

5.1. Adolescent Pregnancy Prevalence Rate

This research has highlighted the need for new strategies that are required to address the gaps in the current programmes and emerging issues, the biggest being adolescent pregnancy. Reproductive health services need a new approach that will attract and serve adolescents effectively ensuring that the quality of SRH services for the adolescents is not compromised and is gender sensitive. Understanding the burden of adolescent pregnancy and their associated risk factors and available services to address adolescents' needs is of paramount importance.

One of the study's objective was to establish the level of adolescent pregnancy in Zimbabwe. The study findings show that pregnancy prevalence rate among all adolescents aged 10-19 years was 9%. A similar pregnancy rate was reported by a study of teenage pregnancy among girls aged 12-19 years in Hurungwe District, Mashonaland Central Province[7]. A further breakdown by age groups shows that pregnancy prevalence rate was less than 1% among adolescents aged 10-14 years and 17% among those aged 15-19 years.

The study's adolescent pregnancy rate of 17% among adolescents aged 15-19 years is lower than the 24% reported by both ZIMSTAT (2015) and ZIMSTAT and ICF International (2012). There is a possibility in the current study that some of the women who were currently pregnant did not report on their pregnancies because of the social norms that are against pre-marital sex. There was also a significant number of reported cases of men who refused their wives who were eligible respondents to be interviewed for fear of the law. Although a low pregnancy rate was reported, conclusions can be drawn from the proxy measure of adolescent pregnancy, i.e. having a sister/sisters who became pregnant before the age of 18 years. This measure shows a higher adolescent pregnancy rate (26%) than the self-reported rate and this is closer to the adolescent pregnancy rate reported by ZIMSTAT (2014). The under-reporting of pregnancy, not only undermines attempts to document and explain adolescent pregnancy, but also compromises policy interventions to address the problem. However, FGDs with male and female adolescents, community and key informants also reiterated adolescent pregnancy as a national problem.

5.2. Factors Contributing to Adolescent Pregnancy

Individual Level

The study found the following individual factors to be significantly associated with adolescent pregnancy: age, ethnicity, marriage, alcohol/drug abuse, self-efficacy, knowledge on pregnancy and attitudes towards adolescent pregnancy, sexuality and condoms. Age was found to be positively associated with adolescent pregnancy, with older adolescents more predisposed to pregnancies. Ethnicity was also associated with adolescent pregnancy, with the adolescents of foreign descent more likely to get pregnant than the local tribes.

Adolescent pregnancy was more likely to be prevalent among adolescents who were married than the never married. This is apparent as in most cultures in Africa, and Zimbabwe in particular, marriage marks the beginning of childbearing and married women are expected to start bearing children. Studies have reported that adolescents who marry early are less likely to use contraceptives to delay the first pregnancy (Santhaya et al., 2010; UNAIDS, 2010). This is a concern to the society and the nation at large, as adolescents marry, they start having children early, and are more likely to face health




and socio-economic consequences. The study also found that adolescents who used contraceptives during their first sexual encounter were less likely to become pregnant compared to those who did not use contraceptives. Though contraceptives have a positive effect of preventing pregnancy, most of the adolescents did not use contraceptives at first pregnancy and on sexual encounter in the 12 months preceding the survey. As a result, they end up getting pregnant. Because their bodies are not yet physiologically prepared to produce babies, they are more likely to experience health problems, as well as their babies. They are also more likely to face complications during delivery and are vulnerable to illnesses and death due to early childbearing.

Alcohol abuse during first sexual encounter was associated with adolescent pregnancy. Adolescents who reported that they or their partner were under the influence of alcohol/drugs on their first sexual encounter were less likely to have experienced a pregnancy compared to those who were not under the influence of alcohol/drugs. The finding is contradictory to other studies that have found alcohol to a contributing factor to adolescent pregnancy[15]. This could due to the small number of adolescents who were under the influence on their first sexual encounter.

Adolescents who had confidence in refusing sex where less likely to become pregnant compared to those with no confidence. The ability to refuse unwanted or unprotected sex is critical in preventing adolescent pregnancy. Therefore, it is very crucial to build skills and confidence among adolescents to reduce adolescent pregnancies.

Adolescents with no comprehensive knowledge on pregnancy were more likely to get pregnant than their counterparts with comprehensive knowledge. This finding is supported by other studies that have looked at the association between knowledge of pregnancy and adolescent pregnancy[35]. The SRH needs of adolescents are largely unmet, resulting in widespread misconceptions and misinformation regarding fundamental aspects of prevention and reproductive life. There is a prevailing assumption that adolescents should abstain from sex and relationships, however many of these adolescents are sexually active or desire to be in a relationship but employ poor preventive practices. Secondary prevention should be a priority with this group; adolescents should be provided with clear and accurate information about pregnancy, STIs and HIV, and should be supported in developing skills to negotiate consistent condom use.

Similarly, adolescents with positive attitudes towards adolescent pregnancy, sexuality issues and condoms were more likely to be at risk of pregnancy compared to girls with negative attitudes. However, when confounding factors were controlled, adolescents with a positive attitude towards pregnancy were less likely to get pregnant. Use of condoms is associated with prostitution, thus most adolescents would not want to be associated with that and thus are bound to have negative attitudes as well. The negative attitudes are also influenced by the social norms that are conservative to adolescent sexual engagement and use of condoms.

Interpersonal Level

Adolescents aged 15-19 years in the second, middle and fourth quintiles were more likely to become pregnant compared to those in the highest wealth quintile. This finding is supported by other studies conducted in Zimbabwe[4,7] that found an association between adolescent pregnancy and poverty. Because of poverty, adolescents engage in sexual relationships with older men who provide them




with money, clothes and food in exchange of sex. As a result, most of the girls may have no control in refusing unprotected sex and as a result, end up pregnant. There is need to equip adolescents with the relevant knowledge to enable them to make informed decisions regarding sexual relationships.

The study also found that adolescents who were orphans were at greater risk of pregnancy compared to the non-orphans, with double orphans more at risk to adolescent pregnancy. Studies conducted in Zimbabwe have also reported similar findings35. Many children in the country have been orphaned as their parents succumbed to the HIV and AIDS epidemic. This calls for more support at national level for the orphans and other vulnerable children.

Adolescents who received pressure from relatives to get pregnant were at greater risk of pregnancy compared to those who did not receive pressure. Relatives exert pressure on girls to become pregnant in cases where there is poverty in the home. Adolescents who received pressure from friends to get pregnant were less likely to become pregnant compared to those who did not receive pressure. This refutes other studies that have reported on peer pressure[7,10]. However, friends tend to indirectly influence their peers through behaviour. Adolescents who have friends who became pregnant before the age of 20 years were at higher risk of pregnancy compared to those did not have friends who had been pregnant. It is usually said that "birds of the same feather flock together". Sisters also had an indirect influence on adolescent pregnancy as adolescents who had sisters who got pregnant during their adolescence were more likely to be at risk of pregnancy.

At family level, girls are bound to be influenced by the experience of their siblings. In this study, adolescents who had a sister/sisters who got pregnant before age 20 years were more likely to become pregnant compared to those with sisters who did not have a pregnancy. Once an older sister becomes pregnant, the younger siblings may see no problems with the pregnancy and might regard the situation as the norm. This calls for interventions that target families to prevent a cycle of adolescent pregnancy in the home. Lack of discussions on sexuality issues between parents and adolescents is reinforced by cultural norms and taboos that inhibit such discussions. Discussions with parents about sexuality should be encouraged as adolescents who had discussed sexuality issues with their parents or guardians were at a lower risk of pregnancy than those who did not discuss with their parents. Hence, parental-child communication should be promoted and advocated.

Organisational Level

The environment in which adolescents reside also plays a significant role in adolescent pregnancy. Striking differentials of adolescent pregnancy were observed by urban-rural residence and province. Adolescents from rural areas were at greater risk of pregnancy (20%) compared to their urban counterparts (9%). The low rates of adolescent pregnancy observed in the urban areas could be due to poverty which is more prevalent in rural areas than urban areas. Similar findings of urban-rural differentials were reported in Zimbabwe by ZIMSTAT (2015) and ZIMSTAT and ICF International (2012). The same pattern was also observed by province where low adolescent pregnancy rates were found in wholly urban provinces of Harare and Bulawayo compared to rural provinces, with the highest rates found in Mashonaland Central, Manicaland, Matabeleland North and Matabeleland South. Although Mashonaland Central had the highest pregnancy rate, the logistic regression revealed that adolescents from Matabeleland North and Matabeleland South had the greatest odds of getting pregnant. Matabeleland provinces share the same borders with Botswana and South Africa, countries that receive




the highest migrants from Zimbabwe. Girls residing near the borders are more vulnerable to adolescent pregnancy. This may mean that someone is simply crossing the border and impregnating the girl child. There have been press reports about Matabeleland South, where men working in neighbouring South Africa were reported to come back home during Christmas holidays and impregnate girls and go back after the festive season. The high prevalence of adolescent pregnancy in rural areas and provinces with borders calls for more interventions in areas where girls are more vulnerable to adolescent pregnancy.

Community Level

Factors found to be significantly associated with adolescent pregnancy at community level were: religion, religiosity, access to the media and internet and whether one had been touched in a way that they felt uncomfortable. Women who did not belong to any religion and those who belonged to the Apostolic Sect were more likely to report adolescent pregnancy compared to women who belonged to the traditional church. This is in line with other studies that have reported high teenage pregnancies among children belonging to the Apostolic Sects as they are often married off to older members of the church[7]. Also, adolescents who did not belong to any religion had greater odds of getting pregnant. It should be noted that it is not just a matter of going to church that matters, but the frequency. Adolescents who frequently attended the church, e.g. once a week, were less likely to get pregnant compared to those who rarely went to church, i.e. a few times a year. Thus, there is need to encourage youths to be affiliated to some religion as the church instils some morality and discipline in individuals.

The study revealed that adolescents who read the newspaper and watched television were less likely to get pregnant compared to those who did not read the newspaper or did not watch television. Ownership of the radio and TV was also significantly associated with adolescent pregnancy as adolescents who did not own a radio or TV were at greater risk to adolescent pregnancy. Access to the media and ICT is very crucial to adolescents in order to reduce teenage pregnancies. Therefore, programmes targeted at the adolescents should target such types of media for education and advocacy purposes.

Adolescents who owned mobile phones were less likely to be at risk of pregnancy compared to those that did not own. The mobile phone has become one of the latest technology that disseminates information fast and cheaply. Messages on pregnancy prevention should use SMS to spread the message, as is done by Econet, e.g. in 2011 Econet sent SMSs on immunization of children on behalf of the Ministry of Health and Child Care. In that year, the message saw an increase in the number of children that were immunized, including the Apostolics. However, adolescents who used the Internet had greater odds of getting pregnant compared to those who did not use the Internet. Studies have reported that adolescents would want to experiment with what they would have seen or shared with peers on the Internet and thus can view pornography (Action for Life, 2011). Thus, there should be strategies that restrict the adolescents, especially children, from using the Internet and this also involves parental control at home.

The study findings also show that women who had been touched in a way that they felt uncomfortable with were at higher risk of adolescent pregnancy. Sexual abuse was also reported as a driver of teenage pregnancy by JIMAT (2014). There is need to enforce laws that protect adolescents from sexual abuse. Adolescents whose parents talked to them about sexuality issues were less likely to get pregnant. Thus, there is need for parents to discuss with their children about sexual issues, including how to react on such advances.




National Level

The government has set up policies and strategies that address the issue of adolescent pregnancy in Zimbabwe such as the Sexual Offences Act and the Marriage Act which increased the age of marriage to 18 years. Despite these advances, the state still lacks comprehensive, consistent laws and policies to improve ASRH. There is no harmonisation of the policies, e.g. the age of marriage is 18 years while age of consent is 16 years. Among the principal barriers to the promotion of good adolescent sexual and reproductive health are a widespread lack of effective policies and programmes and the failure to involve young people in any existing health promotional activities. Other include lack of financial resources to implement the policies and laws, lack of political commitment, lack of enforcement of laws and policies due to contradictions with traditions and cultural practices, and lack of multi-sectoral collaboration of the ministries and organisations. However, empowerment programmes that teach adolescents about sexual and reproductive health and capacity to build their confidence and self-esteem have been found to be effective as fewer pregnancies and marriages are reported on girls participating in such programmes. There is the need to roll out such programmes to all districts in the country.

5.3. Consequences of Adolescent Pregnancy

Health Consequences

Eleven percent of the adolescents reported that their pregnancy did not end up in a live birth as they experienced either a still birth or miscarriage/abortion. Younger adolescents aged 15-17 years were more prone to miscarriages/abortions compared to the older adolescents aged 18-19 years. The younger adolescent girls are most likely to face such problems because their bodies are not fully developed physiologically for a pregnancy. Other health consequences emerging from the FGDs and KIIs were complications during delivery including obstetric fistula, obstructed labour and uterine rupture, cervical cancer, still and pre-term births, maternal and child morbidity as well as maternal child mortality. Similar findings were also reported in studies on teenage pregnancy (WHO, 2014; UNFPA, 2013; ZIMSTAT and ICF, 2012; Ehlers, 2010). These complications may also mean costs to the nation as children in Zimbabwe receive free treatment, the money which could have been allocated elsewhere for the country's economic development. Among the principal barriers to the promotion of good adolescent sexual and reproductive health, are a widespread lack of effective policies and programmes and the failure to involve young people in any existing health promotional activities. Educators, providers of health and social services, religious and youth leaders, parents (and all those who, in fact, commonly influence adolescent behaviour) often lack awareness of, or sensitivity to, the special problems of adolescents. The main obstacle is lack of training, misinformation or simply embarrassment in discussing matters relating to sexuality.

Socio-Economic Consequences

Pregnancies have negative impact on the adolescents. Adolescents who had experienced pregnancy reported on negative social consequences they faced, the most cited being dropping out of school, chased away from home and abandoned by the man responsible for the pregnancy. Similar findings were also reported in several studies (WHO, 2014; Oyefara, 2009; Wekwete, 2002). Younger adolescents aged 15-17 years were more at risk of dropping out of school compared to the older adolescents aged 18-19 years. Educational attainment is very crucial as it moulds or shapes the girl's future life. In most cases, most of these young women will never go back to school, even with the existence of the school's re-entry policy. This has implications on their future employment and job opportunities. Besides




abandonment by the man responsible for the pregnancy, some of the adolescents also mentioned that they were abandoned by their parents/guardians. Younger adolescents aged 15-17 years were at greater risk of being abandoned by the man responsible for the pregnancy compared to the older ones aged 18-19 years. A tenth of the adolescents reported being chased away from home. Some of the rejected girls may end up homeless and this may lead to child prostitution as the mother may try to fend for herself and the baby. This may breed a cycle of poverty. However, it was noted that not all parents reacted negatively to the pregnancy, but a significant proportion reported that their parents or guardians accepted the situation. This kind of positive reaction is welcome and this should be promoted/encouraged within families and communities to avoid nurturing cycles of poverty among these girls.

6. Conclusions and Recommendations

6.1. Conclusions

The study's findings reveal that adolescent pregnancy is a problem nationally. This concern has been expressed by both the male and female adolescents themselves, the community and the key informants. It is important to understand why adolescents are getting pregnant. Although the adolescent pregnancy rate among 15-19 years has been found to be lower than the ones reported by ZIMSTAT, adolescent pregnancy remains a social and health problem.

The causes of pregnancy from the different levels that have been identified include, among others, age, ethnicity, marital status, self-efficacy, alcohol/drug abuse, knowledge of pregnancy, attitudes of adolescent towards pregnancy and condoms, orphanhood, religion, religiosity, peer pressure, poverty, socio-cultural practices, sexual abuse, social media and the Internet. The causes of adolescent pregnancy identified will help the Government and other organisations working with adolescents to understand why adolescent fertility rate is increasing and help to identify effective interventions to reduce adolescent pregnancy. This calls for interventions that are informed by the research findings, targeting the identified hotspots and the vulnerable groups of adolescents.

Consequences of adolescent pregnancy have also been highlighted and these include dropping out of school, being chased away from home, abandoned by the man responsible for the pregnancy, abandonment by friends, stress, low self-esteem and suicide. However, it was noted that some of the parents and guardians accepted the situation. Education programmes that target the youth should embrace these negative outcomes so that they are able to make informed decisions regarding sexual relationships and to avoid pregnancy. Given the causes and consequences of adolescent pregnancy, the government should enforce the laws and legislations that are in place in order to protect the girl child against pregnancy. The effectiveness of some of the policies is hampered by limited financial resources, lack of law enforcement and lack of political commitment.

6.2. Recommendations

Based on the key findings from this national research, the following recommendations to reduce adolescent pregnancy were made:

Individual Level

- Strengthen female adolescent empowerment through life skills initiatives and revitalization of various female sensitive strategies and programmes




- *These interventions should take a psychosocial approach to building self- efficacy, confidence and deal with stigmatization among female adolescents*
- *Promote adolescent engagement and leadership on ASRHR issues*

- Strengthening Adolescent Sexual and Reproductive Health and Rights (ASRHR) in schools and out of schools
  - *Improve access to Life Skills / Comprehensive Sexuality Education by adolescents in and out of school*

- Address socio-cultural and religious norms and community values that undermine ASRHR and perpetuate adolescent pregnancy in communities
  - *Promote community dialogue on adolescent fertility, and harmful socio-cultural and religious beliefs and practices*
  - *Religious and traditional leaders' dialogue and engagement*
  - *Social mobilization and advocacy*

Community Level

- Social mobilization and advocacy on socio-cultural and religious issues contributing to adolescent pregnancy.
  - *Foster greater community dialogue and engagement, and mobilise local traditional and religious leaders to address socio-cultural and religious drivers of adolescent fertility*
  - *Encourage parent to child communication on sexuality and sexual and reproductive health issues*

- Improve adolescents' knowledge on the laws, policies and constitutional rights of adolescents
- Targeted demand generation interventions / activities for uptake of adolescent sexual reproductive health and maternal, new-born child health (MNCH) services.
- Expand availability and access to quality, safe, adolescent responsive and friendly SRH and MNCH services at sub-national level

Policy Level

- Strengthen a multi-sectoral approach, strategies and interventions that tackle drivers of adolescent pregnancy and child protection violations
  - *Improve educational opportunities for female adolescents to stay longer in school and pursue tertiary education as well as re-examine the school re-entry and non-formal education approaches to facilitate continued education for female adolescents*
  - *Promote social and community dialogue around harmful socio-cultural and religious practices, and mobilize communities to act against these practices*

- Re-alignment of policies and legislation by removing conflicting prescriptions as well as address social dis-articulation of legislation
  - *Expedite legal reviews to ensure harmonization with the current amended Constitution e.g. the Child Marriages Act and the Legal Age of Consent which require urgent harmonization. At present a girl can consent to sex at the age of 16 years but cannot be married until she attains 18 years of age despite being pregnant.*

- Strengthen law enforcement and legal compliance mechanisms as well as improve child protection services in the country




- *Given the huge problem of child sexual abuse (54% of girls age 10-14 years reported to have been forced to have sex/raped), there is need for stricter enforcement of legislative / legal instruments for child protection, including the Child Offenders Act.*
- *Alignment of legislation with constitutional provision, and legal review on penalties associated with child rape and abuse to ensure maximum deterrence through extremely punitive*

- Strengthen investment in Adolescent Sexual and Reproductive Health & Rights (ASRHR), education and child protection services

National Level

- Improve educational, socio-economic and recreational opportunities for adolescents in rural areas.
  - *Strengthen youth empowerment investments in rural areas*
  - *Foster strong linkages between ASRHR and youth socio-economic empowerment programmes*

- Hotspot mapping of adolescent pregnancy at sub-national level accompanied by targeted interventions to address drivers of adolescent pregnancies
  - *Demand generation interventions / activities for uptake of adolescent sexual reproductive health and rights (ASRHR) services*
  - *Expand availability and access to quality, safe, adolescent responsive and friendly SRH and MNCH services at sub-national level*

- There is need for comprehensive, integrated and coordinated multi-sectoral approach to ASRHR, education and adolescent empowerment
  - *Strengthen multi-sectoral coordination of ASRHR and youth empowerment.*
  - *Address fragmented laws and policies through harmonisation of legal instruments*
  - *Improve ASRHR strategy implementation and resourcing*

- Strengthen law enforcement, legal compliance mechanisms and child protection services in the country
  - *Effective resourcing of child protection and law enforcement services*
  - *Advocacy and legal reviews on penalties associated with child rape and abuse to ensure maximum deterrence through extremely punitive sentences*
  - *Empower communities to respect constitutional rights of children and adolescents, and have a zero tolerance of child protection violations as well as report these violations*

- Scale-up provision of targeted social cash transfers for adolescents in poor households to enable vulnerable adolescent girls to stay in school longer and pursue secondary and tertiary education
- Strengthen implementation of National Action Plan on Orphans and Vulnerable Children and Child Protection Services at sub-national levels
  - *Improve investment into social welfare/social work services in local communities to address drivers and consequences of adolescent pregnancy*
  - *Strengthen child protection interventions*

- Strengthen national dialogue and action against child marriages, including constitutional rights of young girls
  - *Policy advocacy, review and alignment.*

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Contraceptive image
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