Chapter 7: Exploring Mobile Phone-Based Counselling Interventions for Preventing Early Unintended Child Pregnancies among Adolescents in Zimbabwe

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Abstract

Mobile phone based counselling interventions for the prevention of early unintended child pregnancies were explored in this study in Zimbabwe. The research was interpreted through an interpretivist paradigm and utilized a qualitative approach (case study) to gain insight into respondents' experiences and interpretation of the role of mobile counselling for the SU of adolescents. Data were gathered using one-on-one interviews of four purposely selected participants; two trained counsellors, one programme coordinator and one official from the Ministry of Primary and Secondary Education of Health and Child Care. Braun and Clarke's six-step approach to thematic analysis (2006) was used to analyse data, with member checking to establish the authenticity of data. Three key themes were identified from the findings. One, mobile phone-based counselling was felt to provide a means to improving adolescents' access to sexual and reproductive health information, services and care, which in rural communities was less available or convenient in physical health facilities. Secondly, the impact of the intervention was limited by issues such as access to phones and network connectivity, the cost of airtime and data, parents restricting access to phones in the home, and a lack of a standardised framework for regulation of service providers. Thirdly, the respondents suggested a way of strengthening the intervention such as the involvement of mobile network operators, accreditation of standards, linkage with school and health referral structures, sensitising communities to build trust of parents, and so on. The conclusion of the study was that mHealth acts as a counselling tool has great potential as a prevention strategy, albeit one that could be best implemented with concerted investments in mobile phone access, provider accreditation and community engagement. Adolescents, counsellors, parents, Ministry of Primary and Secondary Education of Health Services and Child Care and implementers of the programme were recommended to promote the coverage and safety of the mobile counselling as pregnancy prevention tool.

Keywords: mobile phone counselling, adolescent pregnancy, Mental Health, Zimbabwe, digital intervention, school dropout

1. Introduction and Background

Teenage pregnancies is an issue of concern in Zimbabwe. The incidence of teenage pregnancy has persisted with more cases of these situations reported (Nunu, Makhado, Mabunda and Lebese, 2020). Studies show that still as early as 12-17, girls are married, and that pregnant and parenting girls are prevented from continuing with their education (Ngidi, Bhana and Dube, 2025; Murewanhema, Moyo & Dzinamarira, 2023) which supports Nunu, Makhado, Mabunda and Lebese. To reveal the severity of this challenge, the Ministry of Primary and Secondary education of primary and Secondary Education documented more than 4500 pregnancy related dropouts in the year of 2023 which majority (3,942) of these dropouts were recorded in the rural schools. This is particularly alarming in that by 2025 102 girls had dropped out of school due to pregnancy (Chidarikire & Kanyopa, 2026). As reported by The Herald in 2024, at least 680 school going girls aged 10-14 became pregnant in Zimbabwe in the first half of 2023; however the actual figure has likely been significantly higher as only cases that were reported to the Ministry of Primary and Secondary Education of Health and Child Care are used to calculate this figure. Underlying a lot of this is poverty. Girls in poorest families are more than four times more likely to be married by age 18 than those in wealthiest fifth, and child marriage and early pregnancy go hand-in-hand; in the rural, struggling communities, especially in the farming and mining, where older men ply the poor girls with small gifts and promises (Chidakwa, 2023). The districts where child marriage and early pregnancy tend to cluster are also the districts from which farmers and miners harvest tobacco and gold panning, which allows older men to develop particular interest in poor farming districts where girls are older than the age of 18 (Chidakwa, 2023). These are no abstractions on a government spreadsheet. Each is the story of a girl whose education was disrupted—sometimes forever—when she couldn't ask a question, share a fear or seek help without a private place. An attempt has been made by the traditional school counselling to fill that lacuna. In Circular 18, schools are directed to continue the education of a learner who is pregnant without discriminating (Baa-Poku, 2019) while under the School Health Programme of the Ministry of Primary and Secondary Education, the learner can also receive psychosocial support through the group and individual counselling (Baafi, 2020). However, things are different in practice. The available evidence is that qualified school counsellors are too few and counselling services are too little in Zimbabwean Schools. For instance, in a case study of 10 primary schools, Samkange and Dondofema (2016) observed that the counselling services were mostly offered by teachers without counselling qualifications. Recent research further confirms this worry. Chidarikire et al., (2024) found that Primary schools in rural areas have limited access to counselling services and they recommended that the services could be urgently needed to have professionally trained counsellors. Likewise, Magwa and Chindanya (2017) using a sample of 36 school counsellors from Masvingo District indicated the need to further enhance the professional training of school counsellors.

Similarly, Siziba and Kaputa (2022) in their survey of ten rural teachers in Nkayi District found that teachers lack proper knowledge and counselling skills which hampered good provision of guidance and counselling services. If she is too embarrassed, too scared of her parents or just farther away from the closest counsellor office she is not likely to just walk in and request for help. This is where mobile phone based counselling comes in. It is not a substitute for a trained counsellor sitting opposite a struggling girl, but it can get to the weak girl and the other girls in the first place that wouldn't make an appointment to see a counsellor. Zimbabwe's mobile ownership and coverage has been increasing steadily over 10 years, but is far from ubiquitous. There is abundant evidence that young people in Zimbabwe have access to mobile phones. Doyle et al. (2020) conducted a survey of 634 young people ages 13 to 24 years with 62.6% having a cell phone. The share of those age 20 to 24 who had a cell phone was 84.7%, followed by 61.1% for age 17 to 19, age 13 to 15 had

27.0%. A bigger study (Martin et al., n = 17,636, Ages 18-24 yrs.) found an even higher rate of mobile phone ownership - 87.63%. Even though these rates were indicative of a high rate of device use, internet access was still quite low and did not evenly distribute. Doyle et al. (2020) reported that 64.5% of the participants reported access to the Internet, and that access is significantly related to socioeconomic status and level of education. Similarly, Martin et al. (2024) pointed to unequal access to the digital environment for youths in Zimbabwe. In addition, there is also some evidence that mobile technology could support sensitive health and counselling interventions in such a way as to improve their confidentiality. Kaufman et al. (2013) found that 78.1% of Zimbabwean survey takers preferred to answer the same questions using a mobile phone than via a paper-based survey, as mobile phone surveys offer advantages of increased privacy and anonymity for the delivery of sensitive questions. There, there are, however, pragmatic problems. McCarthy et al. (2022) found that mobile data costing was a key feasibility and sustainability challenge to digital health and counselling interventions in Zimbabwe. That's a crucial introduction to the chapter. Alongside classroom instruction, school clubs and community conversations, mobile phone-based counselling is an additional way to connect with adolescent learners in a way that prevents an unplanned pregnancy from derailing their education. At the very least such a phone could give a girl one more way out before making the choice to get pregnant; and it could give an older guy one more target to miss, so they will not choose a girl for pregnancy. For this reason, the aim of this qualitative study was to examine mobile phone based counselling interventions on the prevention of early unintended pregnancy among the adolescent population in Zimbabwe. The study was guided by the following research questions:

- What are the perceived benefits of mobile phone-based counselling in preventing early unintended pregnancies in Zimbabwe?
- What are the barriers that limited the effectiveness of mobile phone-based counselling interventions in Zimbabwe?
- What are the recommended strategies that can be adopted to strengthen mobile phone-based counselling interventions in Zimbabwe?

2. Literature Review

A systematic review of mobile phone interventions to improve young people's sexual and reproductive health in LMICs was done by Feroz et al. (2021). In the overall review, mobile phone based interventions such as SMS, mobile apps and IM platforms were found to enhance adolescents' access to sexual and reproductive health information, to facilitate awareness of contraceptive use and reduce stigma and confidentiality barriers. The authors also noted some of the various difficulties experienced, such as lack of internet connection, insufficient information literacy, language issues, and privacy problems. The review brings together multiple country evidence, however, without exploring lived experiences of mobile phone-based counselling in a particular country. The current study aimed to fill this gap by examining youth perceptions of mobile phone counselling benefits, barriers and approaches to improve mobile phone counselling interventions in Zimbabwe. Meherali et al. (2024) conducted an overview of the digital tools that have emerged for increasing adolescent access to sexual and reproductive health information. Results indicated that digital platforms helped build knowledge and awareness of contraception among the young and inspired them to undertake positive reproductive health behaviours, as well as access the good health information. The authors found the potential of digital technology to be a supplement to the conventional counselling services is great. However, they noted there is limited qualitative evidence regarding adolescent experiences of these digital interventions and factors that affect their effectiveness in different settings. The current study filled this

gap by investigating the experience of mobile phone counselling in the Zimbabwean context with adolescents. To address this, Smith et al. (2026) carried out a systematic review of technology-based adolescent pregnancy prevention interventions. The review identified that the mobile phone interventions contributed to knowledge of reproductive health, empowered decision-making and fostered safer sexual behaviours among young people. The researchers concluded that interactive technology that's confidential and tailored to an adolescent's needs can help to lower the rate at which unintended pregnancies occur. Nevertheless, the majority of the reviewed studies took place in high-income countries, and few studies that included interventions in African contexts were reviewed. The current study aimed to fill this gap by examining mobile phone-based counselling interventions for Zimbra girls and teens in order to prevent early and unintended pregnancy.

Chipako et al. 2024, have recently performed a scoping review on sexual and reproductive health intervention among young people in Africa. The review identified that digital health interventions positively affected adolescents' knowledge on contraception, reproductive health service uptake and encouraged positive health-seeking behaviours. It also, however, noted that a major trend in much of the interventions studied was towards health education rather than counselling, and that there was only limited evidence on adolescents' experiences of digital health counselling interventions. The present study sought to fill this void by focusing on adolescents' perceptions of mobile phone-based counselling, and prevention of early unintended pregnancies in Zimbabwe. Onukwugha et al., (2022) carried out a systematic review of mHealth interventions for promoting sexual and reproductive health services in Sub-Saharan Africa. The review identified how mobile phone interventions positively influenced increased reproductive health service utilization amongst adolescents due to enhanced privacy and confidentiality and provision of accurate health information. The researchers also found interactive mobile platforms were acceptable as compared to traditional health education platforms. They did note, however, that there were many interventions that were poorly theoretically grounded, and that there was limited evidence of long-term effectiveness. The present study thus aimed to fill this gap by examining the perceptions of the benefits and difficulties of mobile phone based counselling interventions amongst adolescents in Zimbabwe.

Sexual and reproductive health interventions for mobile AdYouth in Sub-Saharan Africa: A review of the literature was conducted by Mlotshwa et al. (2025). Through the digitization in the study, it was revealed that digital technologies ensured better access to reproductive health services for mobile and vulnerable adolescents, which helped them to overcome geographical barriers and interact with health care providers without needing help from parents or other caregivers. But the review did indicate that digital inequalities—such as connectivity issues and limited smart phone use—remained obstacles in the effectiveness of digital interventions in many rural communities. The current study focussed on filling this gap by examining the constriction factors affecting mobile phone counselling interventions among the youth in Zimbabwe. To assess the feasibility of digital health interventions, Doyle et al. (2021) explored mobile phone access among adolescent and young adults in Zimbabwe. Approximately two thirds of the young population were affected (lived with) mobile phones and the most popular digital communication modality was WhatsApp. There was an increase in ownership of mobile phones with age and educational attainment, indicating that there was a good coverage of Zimbabwean adolescents for digital counselling interventions. The research also found there are challenges, such as internet fees, a lack of smartphone ownership and privacy concerns. Although relatively little was said about counselling experiences, more attention was directed towards problems of technology access. To fill this gap the present study investigated on one hand the perceived benefits and on the other the perceived barriers to mobile phone-based counselling interventions to prevent early unintended pregnancy as perceived by the adolescents. Dhakwa et al. (2021) assessed mHealth strategic use as a

way of enhancing access for adolescents to sexual and reproductive health services in Zimbabwe. It was concluded that there was an increase in referrals to reproductive health services, HIV services, the use of mobile phone communication, improved confidentiality and reduced fear to seek care as a result of the SMS reminders. Adolescents enjoyed mobile cell communication and its ease of use and privacy. The intervention targeted predominately referral systems however, not counselling specific to preventing unintended pregnancy. The current study aimed to fill the gap, so that mobile phone baseado counselling was viewed as an intervention for the prevention of adolescent pregnancy.

McCarthy et al. (2022) localised an evidence-based and mobile technology-based contraceptive behavioural intervention for Zimbabwe youths. The results indicated that the adolescents favoured interactive counselling through whatsApp/SMS as it allowed them to ask questions regarding the topic without exposing themselves to the public due to privacy and confidentiality. Participants additionally suggested that mobile counselling needs to consist of real life stories, simple words and should provide scope for dialogue with the counsellor. However, the research did not measure how "effective" the intervention was for adolescents, but worked mainly towards developing the intervention. The current study aimed to fill this gap by reviewing perceived benefits, barriers and strategies for improving mobile phone counselling interventions in Zimbabwe. Factors affecting the utilization of digital technologies in youth in Zimbabwe were studied by Martin et al. (2024). The study revealed that age, education and household socio-economic status had significant association with mobile phone ownership and internet use. Those who had higher digital access were more likely to look to online options to find health information as youths. However, there were key inequities between communities across rural and urban areas and access to digital health interventions was uneven. The study did not consider how these digital technologies could be incorporated in the counselling intervention to prevent early unintended pregnancy. The current study addressed this gap by exploring adolescents' experiences of mobile phone-based counselling within both enabling and resource-constrained environments.

Murewanhema et al. (2023) analysed Zimbabwe's increased burden of teenage pregnancy and proposed that urgent action is needed to enhance SRH services for adolescents. The study found that significant factors contributing to teenage pregnancy were poverty, lack of adequate sexuality education, lack of youth-friendly services and short access to reproductive health education. The authors suggest solutions such as digital health technologies to bring reproductive health information to adolescents. Nevertheless, mobile phone based counselling and the perception of its effectiveness in adolescents was not explored by the study. In the present study the focus was directed at filling this lacuna, through an investigation about the potential role of mobile phone-based counselling in preventing early unintended pregnancies among adolescents in Zimbabwe. The literature here has revealed an increase in the use of mobile phone technologies to enhance sexual and reproductive health services to adolescents globally and in the region. Previous research has demonstrated that digital interventions have positive effects on access to information and confidentiality and service use. Most studies have focused on the digital education of health, referral and intervention development, while addressing adolescents' lived experiences of mobile phone-based counselling has received little attention. Furthermore, few qualitative studies have explored the perceived benefits, barriers and strategies for strengthening mobile phone-based counselling interventions for preventing early unintended pregnancies in Zimbabwe. To alleviate some of the above, the present study aimed at an in-depth understanding of the experiences and recommendations of the adolescents in the Zimbabwean context.

3. Theoretical Framework

The theory which guided this study was the Ecological Systems Theory created by Urie Bronfenbrenner (1979). According to Ecological Systems Theory, various environmental systems interact to shape adolescent behaviour, and it is not merely a case of choice (Bronfenbrenner, 1979). Such a lens is suitable when considering mobile phone-based counselling interventions to prevent early unintended child pregnancy among adolescents in Zimbabwe since pregnancy risk is influenced by the family, peer groups, schools, health services and community. Rather, at the microsystem level, cultural barriers in adolescents' lives can pose challenges on open discussion of sexual and reproductive health, or adolescents may receive mixed or restricted information. Platforms like WhatsApp, SMS or phone calls enable mobile phone based counselling, providing a way for young people to contact trained counsellors in a confidential manner, able to ask sensitive questions, receive accurate information and emotional support without fear of stigma. Mobile counselling at the mesosystem level can improve communication between the schools and families and health services through supportive referrals and consistent counselling for adolescents on pregnancy prevention issues. Mobile-based sexual and reproductive health services (mSRHS) have recently been shown to be valued by Zimbabwean adolescents as ways of delivering health services that are also more accessible and offer privacy and confidentiality (McCarthy et al., 2022). The theory also points to the effects of larger environmental systems on decision-making for the adolescent. The exosystem consists of issues that can impact how mobile counselling reaches adolescents, including mobile network coverage and health policies, as well as the availability of youth friendly services. While the increased ownership of mobile phones in Zimbabwe has facilitated digital counselling, mobile phones and the internet as channels to accessing sexual and reproductive health information for some youth remain constrained by internet rates, as well as weak connectivity and IT skills (Martin et al., 2024; McCarthy et al., 2022). Culture, poverty, gender norms and social stigma in relation to adolescent sexuality influence attitudes towards contraception and seeking help, at the macrosystem level. Mobile phone-based counselling can provide such a culturally sensitive and private platform to diminish these barriers and shed light on informed decision making. The chronosystem is also an explanation as to how being more digital has, and the recent development of remote health services has further, increased adolescents' opportunities to receive counselling. Based on this, the general adoption of the theory of Ecological Systems in counselling afforded with mobile phone can be used in assisting adolescents in preventing pregnancy as the multiple influences considered in the theory in which mobile phone reaches can foster adolescents' sexual and reproductive health behaviours.

4. Research Methodology

4.1. Paradigm: The study was guided by the interpretivist paradigm that views reality as being socially constructed through the meanings that people assign to their experiences and interactions (Creswell & Poth, 2024). The paradigm used is suitable for qualitative studies and based on the fact that the paradigm aims to have understanding of the participant's subject in the natural social setting (Cohen et al., 2018). The interpretivist paradigm as used in this study allowed the researcher to investigate the perceptions and experiences of the mobile phone-based counselling programmes for stopping early unintended child pregnancies among Zimbabwean adolescents as perceived by various stakeholders including counsellors, programme coordinators, policy makers, and other stakeholders (Alharahsheh & Pius, 2020). In addition, it allowed for rich, in-depth understanding of the opportunities, challenges, and perceived effectiveness of these interventions from the voices of the participants (Creswell & Poth, 2024).

4.2. Research Approach: The study used a qualitative approach to delve into the experiences, perceptions, and meanings of the participants in relation to mobile phone counselling interventions aimed at preventing early unintended child pregnancies among adolescents in Zimbabwe (Creswell & Poth, 2024). Qualitative research can be used for the study of complex social phenomena in their natural setting, where it is important to understand how the participants interpret their experiences and make sense of them (Denzin & Lincoln, 2018). The strategy used in this study allowed for exploring various practical, technological, cultural, and contextual factors that influence the implementation and utilization of teen counselling interventions via mobile phone from the councillors, programme-level command, policy makers, and young persons' perspectives (Patton, 2015). Qualitative was also used to provide deep and context-specific information which was useful in making recommendations on how to strengthen mobile phone-based counselling interventions to prevent early unintended child pregnancy among adolescents in Zimbabwe (Creswell & Poth, 2024).

4.3. Research Design: The research adopted case study design to allow a deep study of the mobile phone based counselling interventions for prevention of early unintended adolescent pregnancy in Zimbabwean context (Creswell & Poth, 2024). A case study design is suitable if the researcher wants to study a contemporary phenomenon in its context and when the lines between the phenomenon and its context are not sharply distinguished (Yin, 2018). The design in this study allowed for a thorough investigation into counsellors', programme coordinators', policymakers' and other stakeholders' experiences, perceptions, and practices with mobile phone-based counselling interventions (Saruchera & Chidarikire, 2024). It also allowed for the provision of rich contextual evidence of the opportunities, challenges, and perceived effectiveness of these interventions, thereby guiding recommendations for strengthening adolescent pregnancy prevention programmes in Zimbabwe (Cresswell & Poth, 2024).

4.4. Data Collection Methods: Data were generated through one-on-one interviews. This method allowed for focused, in-depth engagement with each participant, enabling the researcher to probe individual experiences and perspectives on mobile-based counselling in detail (Baafi, 2020). Given the small, specialised sample, interviews were considered more appropriate than group discussions, as they allowed sensitive and technical issues to be explored without the influence of group dynamics.

4.5. Sampling Technique: The study employed purposive sampling, a non-probability sampling technique in which participants are deliberately selected because they possess characteristics, knowledge, or experiences relevant to the phenomenon under investigation (Patton, 2015). Purposive sampling is particularly appropriate in qualitative research because it enables researchers to identify information-rich participants who can provide detailed insights into the research problem (Creswell & Poth, 2024). In this study, the technique ensured that only counsellors, programme coordinators, policymakers, and other stakeholders with direct experience of mobile phone-based counselling interventions for preventing early unintended child pregnancies among adolescents in Zimbabwe were included. Consequently, purposive sampling facilitated the collection of rich, relevant, and context-specific data that addressed the study's research objectives (Palinkas et al., 2015).

4.6. Sample Size: The sample comprised 4 participants: 2 trained counsellors involved in delivering mobile phone-based counselling to adolescents, 1 programme coordinator from an organisation implementing adolescent sexual and reproductive health interventions, and 1 official from the Ministry of Primary and Secondary Education of Health and Child Care. Although small, this sample was considered adequate for a case study design, as it provided varied, information-rich perspectives from those directly responsible for designing, delivering, and overseeing the intervention (Baa-Poku, 2019).

4.7. Justification for Participant Selection: Counsellors were selected because they had first-hand experience delivering mobile-based counselling to adolescents and could speak directly to its practicalities, benefits, and limitations (Baafi, 2020). The programme coordinator was included as a representative of the organisation responsible for designing and rolling out the intervention, offering an operational and strategic perspective (Chidarikire & Chikwati, 2024). The Ministry of Primary and Secondary Education official was selected to provide a policy-level view, offering insight into the regulatory and institutional frameworks shaping the use of mobile technology for adolescent sexual and reproductive health counselling in Zimbabwe (Chidakwa, 2023).

4.8. Data Analysis: Data were analysed using thematic analysis, guided by the six-step framework proposed by Braun and Clarke (2006). This framework offers a structured yet adaptable process for identifying, analysing, and interpreting patterns within qualitative data (Braun & Clarke, 2006). The six steps applied were as follows:

- **4.8.1. Familiarisation with the data:** The researcher repeatedly read the interview transcripts, noting initial impressions and recurring ideas (Braun & Clarke, 2006).
- **4.8.2. Generating initial codes:** Relevant features of the data were systematically coded across the full dataset (Braun & Clarke, 2006).
- **4.8.3. Searching for themes:** Codes were grouped into candidate themes reflecting patterns relevant to the research questions (Braun & Clarke, 2006).
- **4.8.4. Reviewing themes:** Candidate themes were checked for internal coherence and distinctness from one another (Braun & Clarke, 2006).
- **4.8.5. Defining and naming themes:** Each theme was refined and clearly described to capture its core meaning (Braun & Clarke, 2006).
- **4.8.6. Writing the report:** The final step involved weaving the themes into a coherent analytical narrative (Braun & Clarke, 2006).

4.9. Trustworthiness of Data: Data became more trustworthy as participants reviewed the transcripts from the interviews and preliminary interpretations for accuracy of capturing their views (Birt et al., 2016). Member checking is known as one of the techniques used to enhance the credibility and authenticity of the qualitative research through the validation of the experiences of the participants by the researcher (Creswell & Poth, 2024). Further, this process allowed the participants to refine and correct or clarify their answers, enhancing the quality and authenticity of the result (Nowell et al., 2017). These procedures served to reinforce the analyst's credibility and the validity of conclusions seen as addressing the meaning the communiquees wished to express and their lived experiences (Lincoln & Guba, 1985).

4.10. Ethical Considerations: To ensure the rights, dignity and well-being of all participants, ethical principles were followed throughout the research process (Creswell & Poth, 2024). The procedure was carried out in such a way that all the subjects have signed informed consent forms. Each subject was informed in detail of the consent purpose, procedure, any possibility of potential risk and benefit of the study and asked for voluntary participation to collect data (Orb et al., 2001). Using pseudonyms ensured confidentiality and anonymity, and all the research data were securely stored and accessed only by the researcher in order to protect the participants' privacy (Israel & Hay, 2006). Participants were also reminded that no punishment would result in withdrawing from a study, that they did not have to answer every question, and that only a few of them were in the process of considering religious issues and options, which the information would be used to address, and not for any other purpose (Resnik, 2020).

5. Discussion and Findings

5.1 Theme 1: Perceived Value of Mobile Phone-Based Counselling in Preventing Early Unintended Pregnancies

This theme explored participants' perceptions of the benefits and potential contribution of mobile phone-based counselling in improving adolescents' access to sexual and reproductive health information, psychosocial support, and pregnancy prevention services. Participants highlighted that mobile phone-based counselling increased access to adolescents who were unable or unwilling to seek conventional face-to-face counselling due to fear, stigma, distance, and concerns about confidentiality.

Participant 1 stated:

Mobile counselling has allowed us to reach girls we would never have reached through the clinic. Many adolescents are too shy or too afraid to walk into a health centre and ask about contraception or relationships. But when they can call or send a message privately from their phone, they open up. I have counselled girls as young as 13 who would never have spoken to me face to face about what was happening to them.

Participant 2 explained:

The advantage of the phone is privacy. A girl can be counselled at night when everyone else is asleep, without her parents or neighbours knowing. This has helped us intervene early, before a relationship with an older man goes too far. We have also used it to refer girls to clinics for contraception before they fall pregnant, which was much harder to do when we only relied on in-person sessions.

Participant 3 added:

Mobile-based counselling has increased our reach in rural areas where distances to health facilities are long and transport is unreliable. A girl can access support from her own community without travelling. This has been one of the biggest strengths of the programme, especially for adolescents who are out of school or whose movements are restricted by their families.

Results showed that mobile phone counselling was seen to be useful as it benefited accessibility, confidentiality, convenience and early intervention opportunities. The results are aligned with the studies of Feroz et al. (2021) in which they observed that mobile phone interventions had a positive impact on the access to sexual and reproductive health information by adolescents and removed stigma and confidentiality as barriers. In the same way, Meherali et al. (2024) found that digital health platforms enhanced adolescents' access to reliable sexual and reproductive health information and facilitated positive sexual and reproductive health behaviours. The finding that privacy facilitated greater disclosure of sensitive information among adolescents was also consistent with that of McCarthy et al. (2022) which found that the participants in Zimbabwe responded favorably to the mobile phone-based counselling methods as they allowed them to communicate anonymously and provided opportunities to discuss sensitive topics that were challenging to explore via face-to-face delivery methods. The capability-enhanced access to mobile counselling services by rural-adolescents reported by the participants resonates with Doyle et al. (2021)'s findings that mobile phone ownership among the adolescents of Zimbabwe opens doors in implementing more digital health interventions outside the traditional points of access. Moreover, the use of mobile counselling for early referral and prevention

aligns with the Zimbabwean evidence presented by Dhkawa et al. (2021) which indicated that mobile Based Adolescent Sexual and Reproductive Health Services (mASRH) resulted in better access to adolescent sexual and reproductive health services (ASRH) in Zimbabwe, which involved confidential communication and referral mechanisms. The present work then adds to the evidence that the mobile phone is not only a communication instrument, but might also be a preventive intervention to especially detect risks at an early stage and provide support, before an unintended pregnancy takes place.

5.2 Theme 2: Barriers and Challenges to Implementing Mobile Phone-Based Counselling

This theme examined the technological, social and structural challenges that limited the effectiveness of mobile phone-based counselling interventions. Participants identified unequal access to mobile phones, poor network coverage, data costs, shared phone ownership, parental restrictions and inadequate regulation of digital counselling services as major barriers.

Participant 1 stated:

Not every girl has access to a phone. Some share a phone with their whole family, which means they cannot call us privately because someone else might see the messages or answer the call. Network coverage is also a problem in some of the rural wards we serve, so sessions get cut off or messages take days to go through.

Participant 3 explained:

Airtime and data costs are a real barrier. Many of the girls we work with come from poor households and cannot afford to buy data bundles to call or message us. We have tried toll-free lines, but even those require a phone that works, which some girls simply do not have. There is also the challenge of parents confiscating phones from their daughters as a form of control.

Participant 4 added:

At a policy level, we have struggled to regulate and standardise mobile counselling services because many are run by different organisations without a unified framework. There are also concerns about counsellor training, because not everyone offering phone-based counselling has the right qualifications to handle sensitive disclosures, including cases of abuse or exploitation.

Results indicated that mobile phone based counselling offers valuable opportunities but also is influenced by digital inequalities and social barriers. The results agree with the study by Doyle et al. (2021) which revealed that while the use of mobile phones is escalating among Zimbabwean adolescents, inequalities of their ownership and access to the internet as well as the cost implies that mobile phones are touchpoints that create unequal access and participation. A similar study by Martin et al. (2024) found that digital technology use was linked to socioeconomic status and access to digital infrastructure and education, indicating that digital interventions might have a potential for creating further inequities regarding adolescent youth's access to digital technology. Data costs faced by participants also align with findings from McCarthy et al. (2022), which include access and affordability as a risk factor for consistent use of mobile-based reproductive health interventions among youth. Findings also align with those of Feroz et al. (2021) that accessibility, digital literacy, privacy issues are typical obstacles that apply to mobile health interventions in LMICs. In the context of adolescent sexual and reproductive health counselling, the issue of confidentiality by way of joint phone ownership

comes into focus. Mobile can offer privacy, but when the device is a family owned one, adolescents may still face being monitored and the fear of disclosure. This finding resonates with the argument made by Meherali and colleagues (2024), that social contexts and threats to privacy warrant attention when developing digital interventions for adolescent health. The worry about fragmented implementation and weak regulations resonates with what Chipako et al. (2024) found that many of the adolescent SRH interventions in Africa lacked coordination and needed stronger implementation mechanisms. This current study has thus helped emerge the following additional findings: mobile phone-based counselling can be effective when it takes into account the affordability, safeguarding, professional standards and the social context in which adolescents use digital services.

5.3 Theme 3: Strategies to Strengthen Mobile Phone-Based Counselling Interventions

This theme explored participants' recommendations for improving the effectiveness, sustainability and accessibility of mobile phone-based counselling interventions. Participants recommended reducing financial barriers, developing regulatory guidelines, strengthening partnerships with schools and health facilities, and improving community awareness about the value of adolescent digital counselling services.

Participant 2 stated:

We need partnerships with mobile network operators to provide free or subsidised platforms dedicated to adolescent health, similar to toll-free helplines. If airtime is no longer a barrier, more girls will reach out before they get into difficult situations.

Participant 4 explained:

The Ministry of Primary and Secondary Education needs to develop clear guidelines and accreditation standards for organisations offering mobile counselling to adolescents, so that we can ensure quality and safety. We also need to integrate mobile counselling services with school health programmes, so that referrals between counsellors, schools, and clinics work together.

Participant 3 added:

Community sensitisation is important too. Parents need to understand that mobile counselling is a protective tool, not something that encourages bad behaviour. If parents are on board, they will not confiscate phones or block their daughters from using these services. We also need more female counsellors trained specifically in adolescent-friendly, phone-based approaches.

The results indicated that, strengthening mobile phone based counselling needs collaboration between technology providers, government institutions, schools, health facilities and the community. The suggestion of cost reduction through agreements with mobile network providers aligns with Feroz et al. (2021), which found “affordability” is one of the factors that affect the sustainability and access to mobile health interventions in low resource settings. This was similar to the call by Chipako et al. (2024) for the need for effective and coordinated implementation frameworks for adolescent sexual and reproductive health interventions. Likewise, Dhakwa et al. (2021) emphasized the need to link mobile health (mHealth) to other health channels for effective linkages and continuity of care. The recommendation to integrate mobile counselling with schools and health services also aligns with the work done in Zimbabwe by Murewanhema et al. (2023) who suggested that innovative approaches like

mobile counselling could play a vital role in enhancing the access of adolescents to reliable sexual and reproductive health information and youth friendly services as a strategy to tackle teenage pregnancy in Zimbabwe. Additionally, community sensitisation is highlighted, consistent with the findings of Meherali et al. (2024) that digital interventions need to account for social acceptance, cultural beliefs and community contexts to effectively engage adolescents.

6. Conclusion

This qualitative study found that mobile-phone counseling had a potential for use as a preventive intervention in tackling early unintended pregnancies in Zimbabwe and in particular, could make counseling services confidential, convenient and accessible by reaching out-of-reach populations and individuals who were socially supervised or stigmatized. The study validated privacy and less dependence on physical infrastructure as the most desirable aspects of the intervention to access and support vulnerable adolescents to prevent escalation of relationships into pregnancy. At the same time, the study also identified a number of structural barriers to the reach and the consistency of the intervention, such as unequal access to phone and data/internet, phone sharing between households, and a lack of a standardised regulatory framework. The study's findings suggested that preventing potential through mobile phone counselling would require coordinated investment in affordable connectivity, formal accreditation of the service providers, better facilitating linkages with school and health referral systems and sustained engagement with the community to develop novel trust in digital counselling platforms.

7. Recommendations

7.1 Recommendations for Adolescents: Adolescents should be encouraged to make use of available mobile counselling helplines and to treat them as a safe, confidential first point of contact when facing pressure from older partners or uncertainty about their sexual and reproductive health. Adolescents should be made aware of their right to access such services without needing parental permission where confidentiality protections apply.

7.2 Recommendations for Counsellors: Counsellors should receive specialised training in adolescent-friendly, phone-based counselling techniques, including how to identify and respond to disclosures of exploitation or abuse. Counsellors should work to establish trusted, ongoing relationships with adolescent clients despite the remote nature of the platform.

7.3 Recommendations for Parents: Parents should be sensitised on the protective value of mobile counselling services and encouraged to support, rather than restrict, their adolescent children's access to confidential helplines. Parents should be engaged as partners in prevention efforts rather than treated as obstacles to adolescents seeking help.

7.4 Recommendations for the Ministry of Primary and Secondary Education of Health and Child Care: The Ministry of Primary and Secondary Education should develop a national regulatory and accreditation framework for mobile phone-based counselling services targeting adolescents, and should facilitate partnerships with mobile network operators to reduce cost barriers to access. The Ministry of Primary and Secondary Education should also promote integration of mobile counselling platforms with school health and referral systems.

7.5 Recommendations for Programme Implementers: Implementing organisations should invest in expanding network coverage and subsidised or toll-free access points in underserved rural areas, and should conduct regular community sensitisation campaigns to build trust in mobile counselling as a legitimate and protective service for adolescents.

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