# Chapter 18: Socio-economic and Cultural Determinants of Adolescent Pregnancy in Zimbabwe

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**Abstract**

*In Zimbabwe adolescent pregnancy is a problem of education and development particularly in the more marginalised rural and peri-urban communities. This chapter focuses on the interplay between socio-economic disadvantage and cultural norms and considers its impact on adolescents' vulnerability to pregnancy. Its aims were to examine household- and community-level determinants, to explore gendered cultural expectations, and to uncover institutional barriers to education, to social protection and adolescent-responsive health services. It was an interpretive study based on a qualitative multiple case study design in three selected districts, in rural, farming and peri-urban areas. 45 subjects were chosen in maximum-variation purposive sampling which comprised of 15 adolescent mothers, nine parents/guardians, six teachers, six health, three social workers, three traditional leaders and three religious leaders. 33 semi-structured interviews and three focus-group discussions were conducted where data were generated. Interviews were audio-recorded and transcribed verbatim and analysed using reflexive thematic analysis. Five themes emerged from the analysis: household economic precarity; educational exclusion; gendered power inequalities; cultural and religious control of adolescent behavior; and lack of or stigmatizing support services. The chapter ends with a conclusion noting the role of the intersection of structural and cultural inequalities to produce adolescent pregnancy. It suggests making sure that those who have left school are re-entry, social protection, adolescent responsive services, implementation of laws on child marriage and community led norm change, including involving parents, traditional and religious leaders, and boys/men.*

**Keywords:** adolescent pregnancy, socio-economic determinants, cultural norms, gender inequality, Zimbabwe

## 1. Introduction and Background to the Study

Adolescent pregnancy is a critical public-health, educational, gender-equality and socio-economic development issue. Adolescent is defined as 10 to 19 years old (WHO, 2024) and as per WHO (2024), millions of girls in low and middle-income countries are becoming pregnant each year. Each year, an estimated 21 million girls aged 15-19 years in low and middle-income countries (LMICs) become pregnant—with an estimated half of these pregnancies being unintended (Bitewa et al., 2026). Adolescent mothers are at higher risk for the selected maternal complications and theirchildren are at higher risk for severe neonatal complications, low birth weight and preterm birth (WHO, 2024). The

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consequences of adolescent pregnancy relate not only to reproductive health but also touch on issues surrounding education, social protection, child rights, and sustainable development. Single explanations of the individual nature of pregnancy based on lack of knowledge or on irresponsible behavior are analytically inadequate. Within the household, school, relationships, community and service organizations that structure resources, information and authority, adolescents make decisions. Several factors, such as poverty, child marriage, gender inequality and disrupted schooling, as well as limited access to confidential reproductive-health services, can interact to limit meaningful choice (United Nations Population Fund [UNFPA] et al., 2023; WHO, 2024).The evidence from Zimbabwe strongly suggests that rates of adolescent pregnancy are socially differentiated and determined by economic, educational, family, and cultural and health-service circumstances. The National Assessment of Adolescent Pregnancies in Zimbabwe gathered survey and qualitative data from six provinces and highlighted the importance of gaining insights into the adolescents' experiences and perceived needs (UNFPA et al., 2023). This is complemented by earlier national demographic evidence which highlighted important links between fertility, schooling, household wealth, use of contraceptives and place of residence (Zimbabwe National Statistics Agency [ZIMSTAT] and ICF International, 2016). The introduction of formal protections in Zimbabwe via the Education Amendment Act 2020 and Marriages Act 2022. The former has the back of those who are pregnant and parenting while studying while the latter bans marriage under 18. However, even with formal legal protection, the existence of informal unions is not abolished, nor is the stigma of informal unions, poverty informal unions, community practices that contribute to adolescent pregnancy or implementation gaps (Marriages Act, 2022), or should be. Qualitative investigation is needed due to the disjuncture between formal rights and practice.

It is against this background that this chapter investigated the socio-economic and cultural determinants of adolescent pregnancy in Zimbabwe. It is guided by three objectives, which are to:

1. explore household and community-level socio-economic conditions associated with adolescent pregnancy,
2. examine how gender norms, marriage expectations, religious beliefs and cultural practices shape adolescents' reproductive experiences,
3. identify institutional barriers affecting adolescents' access to education, social protection and adolescent-responsive health services.

The chapter argues that adolescent pregnancy is not attributable to a single cultural practice, household characteristic or individual behaviour. It emerges from the interaction of economic precarity, gendered power relations, educational exclusion, institutional shortcomings and community meanings attached to sexuality, marriage and motherhood.

## 2. Literature Review

### 2.1 Adolescent Pregnancy as Structural Inequality

International scholarship increasingly treats adolescent pregnancy as both a manifestation and a mechanism of inequality. Girls with limited education and low socio-economic status generally experience higher pregnancy risk than more advantaged peers (WHO, 2024). Poverty can restrict access to school materials, transport, menstrual-health products, communication technology and clinical services. Pregnancy may then deepen disadvantage by interrupting education, increasing unpaid care work and limiting employment opportunities.

### 2.2 Poverty, Livelihoods and Transactional Relationships

Zimbabwean and regional evidence links household poverty, food insecurity and limited livelihood opportunities with adolescent pregnancy and child marriage (UNFPA et al., 2023; United Nations Children's Fund [UNICEF], 2025). Transactional relationships should not be reduced to moral failure. They may represent efforts to meet material needs within gendered economies in which older or better-resourced partners possess greater bargaining power. Agency remains present, but it is exercised under constraint.

### 2.3 Education and School Exclusion

Education can be protective because it provides knowledge, social networks, trusted adults and future aspirations. Conversely, irregular attendance and dropout can increase vulnerability. The relationship is reciprocal because educational exclusion may precede pregnancy, while pregnancy can intensify disengagement. Although the Education Amendment Act protects access, re-entry can be weakened by fees, childcare, stigma, inflexible timetables and resistant attitudes (Education Amendment Act, 2020; Khumalo & Hadebe, 2024).

### 2.4 Gendered Power and Reproductive Decision-Making

Gender norms influence who initiates relationships, control resources, decides whether contraception is used and bears the consequences of pregnancy. Girls may be expected to remain sexually respectable yet receive little practical information. Once pregnant, they may face visible stigma and educational interruption while male partners experience fewer consequences. Age-disparate relationships can intensify inequalities in income, authority and experience.

### 2.5 Child Marriage, Culture and Religion

Child marriage and adolescent pregnancy are and should be treated separately but are linked. In certain instances, marriage can precede pregnancy, and girls are expected to prove their fertility shortly after entering into marriage; alternatively, pregnancy may come first and marriage may be felt to be a way in which family respectability can be restored. Zimbabwe has legislation that sets the minimum age of marriage at 18 years (Marriages Act, 2022). The evidence gained from Chipinge District offers valuable clues to the cultural and relational contexts where early pregnancy might come into production. Marashe (2017) conducted a qualitative study about the traditional beliefs and practices of Shona people and reported that among the mentioned customs, one was the custom of marriage of children which Marashe termed kuputsa; a kind of pledged or forced child marriage. Marashe also noted two other practices that he considered to "enhance vulnerability" to the possibility of an HIV infection: barika (polygyny) and kugara nhaka (wife inheritance). While HIV/AIDS was the focus of the study, there is a lot of light shed there to some of the mechanisms that can apply to early conception. Kuputsa can give a girl the right to move from the control of her home to be part of her initial marriage, within which either a much older spouse or household members and customary norms may have considerable authority over sexual relationships, practice of contraceptive and birth timing. A marriage license may legitimate sexual relations and fertility may be expected to show commitment to marriage, especially so if motherhood is encouraged as an indicator of commitment. Loss of decision making power over both economic and financial matters and dependency may consequently diminish the adolescent's ability to postpone first pregnancy or to agree to the use of contraceptives or to stay in school. Pregnancy also may further solidified the link by adding the additional burden of caregiver and of dependency that can reinforce

the link between child marriage, dropping out of school and socio-economic vulnerabilities. Marashe (2017) gives further elaboration of barika and kugara nhaka, which further demonstrate the unequal sharing of sexual and reproductive power through marriage systems. Although these findings do not claim that such practices always lead to adolescence pregnancy, the findings reveal that customary practices in marriage can create a relational space where relations between men and women are power-laden in which the exercise of reproductive autonomy is limited and early child-bearing becomes socially expected. The study also found that there were practices that were retained, amended or discontinued by communities as a result of HIV and AIDS. This shows that Shona culture is not static and that uniform as well as culturally-based dialogue may help re-interpret practices which increase girls' vulnerability to early marriage and pregnancy. Further, Marashe (2017) noted that health information sent predominantly in English may be less comprehensible to rural people who speak in Ndau and suggested that health messages be sent using the language. This finding suggests a need for linguistically appropriate sexual and reproductive health care and sex education education for adolescents that they can understand and apply to adolescent pregnancy prevention. Traditional and religious leaders can and do reinforce restrictive norms, but also can engage and mobilise communities to postpone marriage, raise girls and promote local norms about changes in gender and fertility norms that is acceptable to communities (UNICEF, 2025).

### 2.6 Parent–Child Communication and Sexuality Education

Protective communication is accurate, sustained, non-judgemental and developmentally appropriate. Communication centred solely on warnings, abstinence or punishment may not equip adolescents to recognise coercion, negotiate boundaries or navigate services. Comprehensive sexuality education should address consent, contraception, healthy relationships, gender equality and referral pathways. Information alone remains inadequate if services are inaccessible or stigmatising.

### 2.7 Adolescent-Responsive Services

Service barriers include distance, cost, inconvenient operating hours, insufficient privacy, anticipated disclosure and judgemental provider attitudes. These barriers are differentiated by rurality, disability, marital status and household resources. The physical presence of a clinic does not guarantee practical accessibility. Effective provision must therefore be confidential, acceptable, equitable and connected with education, safeguarding and social protection.

### 2.8 Research Gap

Existing Zimbabwean research provides valuable prevalence estimates and policy analysis, but quantitative associations do not always explain how adolescents experience bounded choice or how institutional and cultural processes interact. This study addresses that gap through a qualitative multi-stakeholder design that includes adolescent mothers, caregivers, educators, health workers, social workers and community leaders.

## 3. Theoretical Framework

### 3.1 Bronfenbrenner’s Bioecological Theory

The chapter draws primarily on a bioecological framework of development, in which Bronfenbrenner and Morris (2006) theorize development as an interplay between process, person, context and time.

Modern uses focus on four aspects that are related to one another: process, person, time and context. This formulation prevents this blacklisting/redlighting type of use of the framework by painting a picture of the environment (Tong & An, 2024). Adolescents come into direct contact with parents, partners, peers, teachers, health workers and religious communities at the microsystem level. This level involves communication about sexuality, partner power, household supervision, expectations and treatment from peers and services providers. The mesosystem relates to the links between microsystems. Examples include relationships between families and schools, schools and health facilities, and parents and religious institutions. A re-entry policy can be compromised due to families' lack of support or schools' lack of linkage with social and health services for adolescent mothers. Exosystem includes structures that impact adolescents, but to which they are not directly engaged. Adolescents' opportunities and constraints are shaped by parental employment, household mapping into social protection, funding for health services, school governance and local transport. Macrosystems are more broadly based economic conditions, laws, cultural values, gender ideologies and religious discourses. Within this system work the national laws about marriage and education, as well as social forces around fertility, marriage and acceptable behavior of adolescents. The chronosystem emphasizes the aspects of historical change and life course transitions. Adolescents vulnerabilities can change over time and are influenced by their surroundings, such as the economy, a public-health crisis, legislative actions, or school closings and family loss.

### 3.2 Intersectionality

Intersectionality complements bioecological theory by foregrounding power and the interaction of social locations (Crenshaw, 1989). Age, gender, poverty, schooling, disability, marital status, religion and rurality do not operate independently. Their intersection produces differentiated exposure to risk and unequal access to protection. Combining ecological and intersectional perspectives enables analysis of both nested context and structural power (Roy, 2018).

## 4. Research Methodology

### 4.1 Research Paradigm and Design

The study was situated within an interpretivist paradigm, which recognises that social reality is constructed through participants' experiences and interpretations. A qualitative multiple-case study design was used to examine adolescent pregnancy within three purposively selected districts representing rural, commercial-farming and peri-urban contexts. Each district constituted a case, while the seven participant categories served as embedded units of analysis. This design enabled an in-depth examination of context-specific meanings and systematic comparison across settings and stakeholder groups. The study sought analytical depth and transferability rather than statistical generalisation.

### 4.2 Population and Sampling

The study population comprised people with direct experience of adolescent pregnancy and stakeholders whose professional, family or community roles involved adolescent welfare. Adolescent mothers were eligible where pregnancy had occurred before the age of 20, while adult participants were eligible on the basis of relevant caregiving, educational, health, social-welfare, traditional or religious responsibilities. Maximum-variation purposive sampling was used to recruit 45 participants across the three cases. As shown in Table 4.1, the sample comprised fifteen adolescent mothers, nine parents or guardians, six teachers, six healthcare workers, three social workers, three traditional leaders and three

religious leaders. Variation in participant role and study setting supported comparison of personal, familial, institutional and community perspectives. Recruitment and data generation continued until meaning saturation was judged to have been reached, defined pragmatically as the point at which additional accounts contributed limited new insight to the developing analytical categories.

**Table 4.1** Distribution of Study Participants by Category

| Participant category | Number (n) | Percentage (%) |
|---|---|---|
| Adolescent mothers | 15 | 33.3 |
| Parents or guardians | 9 | 20.0 |
| Teachers | 6 | 13.3 |
| Healthcare workers | 6 | 13.3 |
| Social workers | 3 | 6.7 |
| Traditional leaders | 3 | 6.7 |
| Religious leaders | 3 | 6.7 |
| **Total** | **45** | **100.0** |

*Note.* Percentages are based on the total sample of 45 participants. Values may not sum exactly because of rounding.

### 4.3 Data-generation Methods

In total, 33 semi-structured individual interviews and three focus group discussions (four people each) were used to collect data. The total sample size was 45, all of whom were interviewed and 12 of whom were focus group participants, with no participant doing both the interviews and the focus group. The individual interviews were mainly to elicit accounts that needed to be kept private and sensitive, while the focus-group interviews provided us with a way to access shared community and institutional perspectives, the areas of overlap and where timecycles differ, and the way you negotiate the meaning together. These approaches allowed for the gathering of both detailed individual accounts and interactional data that would be generated by the group discussion to support a qualitative enquiry that is contextually grounded (Creswell & Poth, 2018). Interview and focus-group guides were developed to respond to the research questions and grounded in the bioecological as well as intersectional framework. Their response included household socio-economic conditions, participation in education, intimate partners' relationships and decision-making, SRH knowledge, access to health and protection services, parent–child communication, marriage expectations and family creation, cultural and religious discourses, experience of stigma, and suggested solutions. The guides were pre-tested with some people who had certain characteristics that matched those of the target audience but were not included in the actual sample. Feedback from the pilot was used to make changes to the clarity, order, cultural appropriateness and sensitivity of the questions. All sessions were facilitated by six trained research assistants using easily accessible areas within the study areas providing reasonable privacy for the participants. Communication was in participants' languages. Informed consent/assent was obtained and the sessions audio-recorded, with field notes made to record contextual and interactional data and preliminary reflections for analysis. All the recordings were then transcribed word for word and

translated to English whenever necessary. Each translation was verified with the original recording by a second researcher who was fluent in the relevant language, to allow for re-checking, refinement and/or literal translation of the translated transcript to ensure language and interpretation were as accurate as possible (Temple & Young, 2004). Data generation was carried out parallel to the analysis, which allowed emerging issues to inform further interviews and focus group discussions. This was also a recursive process which helped to determine the level of meaning saturation. The data generation process was carried out until the recruitment of further accounts did not result in further insights regarding the arising analytical categories, considering heterogeneity of the categories of participants and study locations (Hennink & Kaiser, 2022). This ongoing interaction with the data set provided the backdrop to the systematic coding and reflexive interpretation or processes of theme development that are outlined below (Braun & Clarke, 2021).

### 4.4 Data Analysis

The full dataset was analysed based on the preliminary analytic reflections gained through the data generation, using a reflexive thematic analysis as described by Braun and Clarke (2021) who iteratively work through six phases: familiarisation, initial coding, generation of candidate themes, reviewing and refining of themes, defining and naming the themes, and writing the analytic report. The transcripts were read to and fro several times by researchers until they became familiar with the transcripts contents and contexts of the participants' accounts. Initial coding was used to capture explicit meanings, reoccurring experiences, contradictions and experienced observations of interest within the context. Coding then shifted from descriptive and semantic terms to interpretive codes which focused on relationships and institutional processes/power structures. This analysis approach was based on both an inductive one that permitted the generation of patterns from the data as well as a theoretically oriented approach with bioecological and intersectional orientations as sensitizing concepts. A cross-case analytical matrix, reflexive memos and case summaries were used for the process of comparing across districts and categories of participants, to look for convergence and divergence, and to analyze for negative or discrepant cases. The themes were checked for their internal coherence as well as for analytical distinctiveness and connection with the theme of the study, using the coded extracts and the set of data overall. The emergent themes were thus interpretive explanations of the effect of socio-economic, cultural and institutional settings on adolescent pregnancy, and not just summaries based on frequency.

### 4.5 Trustworthiness

Trustworthiness was addressed through credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). Credibility was strengthened through data-source and method triangulation, because accounts were compared across seven participant categories, three cases, individual interviews and focus-group discussions. Preliminary interpretations were subjected to member reflection with selected participants and to peer debriefing within the research team; these procedures were used to test interpretive resonance and consider alternative explanations rather than to seek a single objectively correct account. Dependability was supported through an audit trail documenting sampling, changes to the data-generation guides, coding decisions, theme development and cross-case comparisons. Confirmability was enhanced through reflexive journaling and analytic memos that made researcher assumptions and positional influences visible. Thick description of the settings, participants and institutional contexts supported readers in judging the transferability of the findings.

### 4.6 Ethical Considerations

Ethical clearance was secured from the relevant research ethics committee before generation of data and the response from the relevant district and institutional authorities was obtained for the administration. The final version of the publication should contain the name of the committee and its approval number. For adult participants, informed written consent was obtained. Minor participants (under 18) gave written assent, as well as consent from parent/legal guardian, unless a safeguarding exception was adopted by the ethics committee which would lead to increased risk to the participants if guardian consent were sought. All involvement was on a voluntary basis and participants [were] reminded that they could skip questions or drop out without penalty. Confidentiality was safeguarded using pseudonyms and de-identification procedures, and recordings and transcripts were kept in a secure location and accessible only to the research team. Researchers used a pre-determined safeguarding and referral protocol due to the potential for disclosure of coercion, violence, abuse or distress to arise in the course of the discussions. The focus-group participants were informed that while the members of the Research Team could ensure confidentiality, the team could not ensure that this condition would hold true between the group members.

4.7 Methodological Limitations

The qualitative sample, consisting of a convenient and purposively selected sample, was suitable for probing and contextual inquiry in the study, but not suitable for the statistical estimation of prevalence or association at a population level. Retrospective report might be influenced by recall and by the interpretation of the experiences after pregnancy. Conformity and/or reluctance of individuals to share opinions, ideas and perceptions may have arose through the group interaction experienced during focus group discussions, especially when talking about sensitive cultural and religious perspectives. Triangulation within cases, between methods, and among participant categories provided a wider perspective of the analysis, but these limits did not go away. However, the sample was based on the stipulation that it should not include adolescent fathers or male partners, thus allowing only some limited study of male experiences, responsibility and reproductive decision making. These boundaries should be taken into account when analysing findings and making judgments about their applicability to other contexts in Zimbabwe.

## 5. Findings, Discussion and Analysis

### 5.1 Analytical Overview and Coding Evidence

Reflexive thematic analysis generated five interrelated themes: household economic precarity and constrained agency; educational exclusion; gendered power inequalities; cultural and religious regulation; and inaccessible or stigmatising services. As shown in Table 5.1, themes were developed through movement from semantic codes to focused analytical codes and then to interpretive patterns. Frequency informed, but did not determine, thematic importance; explanatory significance, cross-case distribution, contradictions and negative cases were also considered.

**Table 5.1** Illustrative Coding Pathway from Data-Based Issues to Themes

| Data-based issue | Initial code | Focused analytical code | Final theme |
|---|---|---|---|
| Lack of food, fees and transport | Unmet household needs | Economic precarity structures relationship choices | Economic precarity |
| Dependence on partner resources | Material support from partner | Dependence weakens negotiating power | Economic precarity |
| Irregular attendance | Interrupted schooling | School exclusion increases vulnerability | Educational exclusion |
| Partner resistance to contraception | Limited negotiation | Gendered control of reproductive decisions | Gendered power |
| Contraception associated with promiscuity | Moral judgement | Sexual respectability restricts access | Cultural regulation |
| Fear of recognition at clinic | Anticipated disclosure | Formal privacy is not experienced confidentiality | Service barriers |

*Source: original codebook and transcripts.*

### 5.2 Household Economic Precarity and Constrained Agency

Initial codes included lack of food, school fees, uniforms, transport and stable caregiver income. These codes were grouped under unmet material needs and then interpreted as economic precarity structures relationship choices. Participants' accounts positioned poverty as an active condition shaping school attendance, mobility and dependence on better-resourced partners. Most participants in the interview concurred with idea of dependency on 'blessers' (a.k.a. moneyed boyfriends), and said that:

> *There were times when we did not have enough food at home, and my family could not always provide money for transport and school materials. I began depending on my partner because he helped me with these needs. When I disagreed with him, I worried that he would stop supporting me* (Participant OS, Personal interview 22 May 2026).

Material support did not by itself establish coercion, and adolescents retained agency. Nevertheless, agency was bounded where the loss of a relationship also meant losing food, transport or school materials. The focused code economic dependence weakens reproductive negotiation captured how unequal control of resources could limit the capacity to insist on contraception or leave a relationship.

> *While poverty contributed a lot, it was not the only reason. Limited guidance, too much peer pressure and the difficulty of accessing contraception pills played a major part* (Participant JC, personal interview, 18 June 2026).

The divergent account is essential because it prevents economic determinism. Poverty operated through family relationships, school participation, gendered bargaining power and service access. This finding is consistent with evidence that economic insecurity interacts with child marriage and adolescent pregnancy rather than functioning as a solitary cause (UNFPA et al., 2023; UNICEF, 2025).

### 5.3 Educational Exclusion as Precursor and Consequence

Codes such as irregular attendance, inability to pay costs, domestic labour and poor progression were organised under school disengagement increases vulnerability. School absence reduced access to structured activity, trusted adults, peer support and future-oriented aspirations.

> *I stopped attending school because my family could no longer afford the fees, uniform and transport costs. I also had to help with household responsibilities, and eventually I did not return* (Ado Mom SM2, Personal interview, 22 April 2026).

After pregnancy, childcare, continuing poverty and stigma generated a second form of exclusion. The focused code legal inclusion but practical exclusion captured the gap between statutory re-entry and the capacity to attend, progress and complete schooling.

> *Given the legal provision and right to education, I wanted to return to school, but I had no one to care for my baby. My family shunned paying fees and other school costs. Teachers and other students laughed at me, and I could not stand being judged, so I withdrew.* (Ado Mom PU, Personal interview, 04 July 2026).

Sometimes participants expressed contrasting views on pregnant adolescent learners. One teacher argued, "*Allowing adolescent mothers to return to school gives them an opportunity to complete their education and rebuild their future*" (Teacher 02, Personal interview).

While parents expressed reservations saying, "*We support their education, but we worry that immediate re-entry may be interpreted by other learners as making adolescent pregnancy acceptable"* (Parent, focus-group discussion)

The contrast demonstrates that policy implementation occurs within contested moral settings. Macrosystem rights are mediated by family support, school practice and links with childcare and welfare services. Re-entry should consequently be evaluated through sustained participation and completion, not enrolment alone (Education Amendment Act, 2020; Khumalo & Hadebe, 2024).

### 5.4 Gendered Power Inequalities

Codes concerning partner refusal, fear of abandonment, age difference, male resource control and blame directed at girls produced two analytical codes: gendered control of reproductive decisions and feminisation of responsibility. Knowledge of contraception did not necessarily produce capacity to use it.

> *I tried to urge my boyfriend to wear a condom, but he refused saying a sweet is not tasty if eaten wrapped. I felt powerless realising that my views were not considered and valued. (Ado Mom 05, individual interview, 10 March, 2026).*

Pregnancy also created asymmetrical consequences. Girls' pregnancies were visible and could lead to shame, school interruption and caregiving, while male partners could deny responsibility or continue schooling. During the interview, a social worker stated:

*The girl often leaves school, faces community judgement and assumes responsibility for the child, while the male partner may continue with his education or employment with few consequences" (SW-07, individual interview, 16 July 2026).*

At the same time, a supportive Form 6 learner had this to say: "*I accepted responsibility and supported her return to school while we shared the childcare responsibilities"* (F6-4, Personal interview, 8 May 2026).

The positive case should be retained to avoid representing male behaviour as uniform. The broader interpretation concerns patterned inequality in responsibility and decision-making. Intersectionality further shows how adolescent mothers were treated simultaneously as children requiring protection and as adults expected to assume maternal duties.

**5.5 Cultural and Religious Regulation of Sexuality, Marriage and Fertility**

Initial codes also featured abstinence-only messages, the subject of sexuality was not to be discussed, contraception was a sign of promiscuity, family honour, marriage after pregnancy and pressure to prove fertility. Interestingly, intra-household communication proved to be a factor affecting adolescents' access to knowledge and advice about reproductive health. Qualitative responses indicated that conversations about sensitive health and relationship topics were frequently couched in term of warning people of safe behaviors instead of engaging in open, developmentally appropriate conversations. One adolescent mother stated that they would face this communication barrier as follows: 'As a matter of fact, in the house sensitive matters relating to health were never discussed. We were cautioned against this and whenever I wanted to ask questions, I was cautioned to behave properly and I stopped asking' (Ado Mom 03, PID, 15 February 2026).

This account raises the possibility of moral pedagogy functioning to replace meaningful mother-child discourse about sexuality. The lack of continuation of asking questions suggests that the environment did not just impedes access to information but also created a less enabling communication situation for the participant to keep seeking help. These initial codes lack of open communication, questions to receive moral warning and withdrawal from seeking assistance, therefore were bundled together and amalgamated in the analytical code of moral regulation constrains access to guidance. The microsystem aspect relates to how interactions with teen's caregivers affect access to information and support, as shown in the quotation. The bioecological framework views the household as a proximal environment where the adolescent learns and acquires knowledge, attitudes and practices in seeking help. Adolescents may not turn to caregivers if questions are perceived as proof of misbehaviors, but rather seek advice from peers, with a partner with whom they have a close relationship, or from an informal source. From an intersectional lens, the silence is also a gendered one as adolescent girls can face heightened pressures around adherence to notions of respectability and respect of the family name. The finding does not imply a lack of concern by caregivers for the welfare of the adolescents. Instead, parents or carers may have wanted to 'look after' adolescents, as shown through discipline and warnings about behaviour, and felt unable to communicate with them because they were not confident or using the right words and/or information. The analytical interest of the quotation thus is in the tension between intentions of protection and practices of communication restriction. This discovery starkly highlights the need for such interventions, aimed at providing parents and guardians with culturally appropriate approaches on how to talk about sensitive health issues without impacting with judgment, intimidation or moral condemnation.

Parents' accounts evidenced that while they were reluctant to discuss sexual health issues, this might be because they feared giving information might signal endorsement of behaviour they deemed inappropriate for their family, consistent with the adolescent mother reports. One parent said “I didn't want to talk about health issues for fear that this would be perceived as 'promoting' behaviors” (PG-02, focus-group discussion). As seen in the quotation, there is a tension between parents' intentions and adolescents' need for accurate guidance that is accessible. The parent doesn't outright deny the value of communication. Rather, the account points to self-perceived repercussions of entering into such conversations. The original coding was to avoid excessive praise for inappropriate behaviour and to avoid topics that are likely to cause offence. The following descriptive codes were then combined into a focused analytical code: 'protective intentions constrain open communication The ‘fear of encouraging’ is analytically significant. It places the parent's ambivalence in the broader moral and social context. The worry isn't just the discomfort it causes but also fear of judgment from family or community. The extract illustrates in the bioecological context how the interaction in the household microsystem could be shaped by macrosystem norms of adolescent deservingness and acceptable family behaviors. This quote is an insight into why teenagers are often behaviourally warned – but not given enough practical advice. However, evidence is not found to support parents were without concern for the welfare of their adolescents or opposed to any type of sexual health education. It is possible to interpret this as a defensive one where the parents wanted to protect their child and they were doing this by avoiding them, and so they were not given enough opportunity to communicate freely.

There was an alternative view that pregnancies that were "out of wedlock" created pressure for union formation. Presumably after getting married, teens might be counted on to have babies, even when another education was still a dream. The idea of bearing children is aimed at cementing the marriage as well as proving one’s fatherhood. Embarrassing cultural and religious reports were disputed internally. Some leaders were in favor of later marriage, more education. This is analytically imperative as culture is dynamic and can offer source for change through rights (UNICEF, 2025).

**5.6 Inaccessible, Fragmented and Stigmatising Services**

An important institutional factor in adolescent pregnancy was found to be access to adolescent-responsive and confidential health care. Some of the participants seemed to indicate that availability was not necessarily equated with practical access to services. Anticipated judgement, confidentiality and potential knowledge of family/community members were concerns that had an impact on whether adolescents sought help. One adolescent mother explained: “I did not come to the clinic as I did not want the people from my community to know I was there as people in my community went to the clinic, and I did not want them to know I had sought out their advice” (Ado Mom 02, individual interview).

Initially codes were expected provider judgement, fear of disclosure and avoidance of formal services. These descriptive codes suggest that the participant's concern was not just the services provided in the clinic. Instead, the participant judged the clinic as part of a greater network of clinics in their community in which healthcare workers, families and other members of the community may have known each other. This in turn served to undermine the participant's expectation of confidentiality of the service. Significantly, the quote does not state that clinics have shared the details of the participant nor have been judgmental in so doing. This indicates the participant's expectations of these behaviors. It is important, as well as analytically significant, to distinguish between experienced and anticipated barriers as some service users may be dissuaded from using a service due to fear of judgement or fear of disclosure, without the confidentiality barrier actually being documented. Expected stigma can limit access, as much as actual discrimination.

The healthcare workers' perspective on these issues resumed an institutional point of view. One healthcare worker described the conflict between the professional need to maintain confidentiality of the adolescent, and conditions in practice where “we try to talk to them in isolation and protect their info however because of the restricted space for consultation, shortage of personnel and also the huge quantity of patients, sometimes that is difficult” (HW-02, individual interview).

Initial coding of this extract was to commitment to confidentiality, inadequate consultation space, staffing constraints, high levels of service demand. The codes were then aggregated to the main analytical code institutional setting limits confidential service provision. An expressed commitment to privacy through use of the term “we try” and reference to infrastructure, staffing and patient numbers indicate conditions which may make the consistent implementation of the confidentiality practices difficult for the participant. Taken together, the two statements show an overlap in the concerns of adolescents and a description of provider service conditions. The adolescent's story illuminates perspectives on confidentiality reported by the service users and the healthcare worker's story potential constraints experienced within the institution that may foster those perspectives. This comparison underlined the fact that formal confidentiality does not ensure experienced confidentiality in general. In the bioecological context these barriers function at multiple levels in an interrelated fashion. Relationships between adolescents and the health care provider are part of the microsystem and relationships among the health facilities, families, and community networks are part of the mesosystem. Staffing level, design of the facility and allocation of resources is at the exosystem. The macrosystem encompasses broader norms about teen behaviour, conceptions of family power, and community notions of respectability. Any concerns about the service-access problem therefore must be guided by a consideration of the perceptions of adolescents as well as the actions of providers. It is a result of the interplay between individual expectations and community relations and institutional capacity. The results demonstrate the need to distinguish between physical availability and meaningful accessibility, too. Being located in a community doesn't mean that a clinic is readily seen as confidential, acceptable or safe to approach by young people. Adolescent responsive care, therefore, needs appropriate service as well as adequate consultation area, clearly explained confidentiality practices, trained staff and communication that will reassure the adolescent that his or her information will be handled appropriately. The fragmentation of services placed the burden of engaging with school, clinics and social-welfare systems on adolescents. The code institutional disconnection covered situations where information was not offered along with contraception; or clinical care was not coupled with psychosocial support; or where there was not material support for school re-entry. The positive case can recognize transferable practice. On the ecological aspect it shows that even if suitable services are provided, they can be undermined by the weaknesses of the mesosystems.

There are no specific requirements for this course.

The themes were complementary to each other. One potential pathway was from household's economic vulnerability to a context of experiences with interrupted schooling and unmet need to reduce family size, to relying on a material secure partner, to reduced ability to negotiate contraceptive use, to perceived stigma in accessing family planning services, to pregnancy, to increased pressure for marriage and to ongoing schooling avoidance. It is an explanatory pattern and not a sequence to be followed. Well support for families, providers and ongoing education can break the pathway. Interactions among household, relational, institutional and societal-level processes provide a perspective that can be understood through the lens of bioecological theory. Intersectionality helps to explain the distinction in consequences of those interactions on the basis of age, gender and wealth, location, disability, schooling

and marital status. The joint analysis can thus be used to refute single-cause explanations and to situate adolescent pregnancy as part of a pattern of layers of structural and relational constraints.

### 5.7 Cross-Case and Integrative Analysis

The themes were mutually reinforcing. A plausible pathway moved from household economic precarity to interrupted schooling and unmet needs, then to dependence on a materially secure partner, weakened contraceptive negotiation, avoidance of stigmatising services, pregnancy, pressure to marry and continued educational exclusion. This is an explanatory pattern rather than a universal sequence. Protective family relationships, supportive providers and continued schooling could interrupt the pathway. Bioecological theory explains how household, relational, institutional and societal processes interact. Intersectionality clarifies why those interactions have differentiated consequences according to age, gender, wealth, location, disability, schooling and marital status. The combined analysis therefore rejects single-cause explanations and locates adolescent pregnancy within an accumulation of structural and relational constraints.

## 5.8 Conclusion

The study is therefore conclusive that adolescent pregnancy in Zimbabwe is not just a result of adolescent irresponsibility because it is not an isolated phenomenon in reproduction. It is a product of relationships and institutions that have unequal distribution of knowledge, resources, authority, consequences. Household poverty reduces options, educational disengagement reduces protective environments, unequal gender relations diminishes reproductive negotiation, restricted norms limits communication, and fragmented services make it hard to get confidential support. While laws are an important basis, law-to-landcase disconnect shows that laws need resources, mechanisms of implementation, community involvement and accountability mechanisms. A successful action programme should embrace a wide range of sectors, have a rights approach and pay attention to preventing unintended pregnancy and to protecting pregnant and parenting adolescents.

# 6. Recommendations

### 6.1 Strengthen Household Social Protection

Expand predictable assistance addressing food insecurity, school costs, transport, menstrual-health needs and childcare. Eligibility mechanisms should avoid punitive conditions that exclude the most vulnerable.

### 6.2 Improve School Retention and Re-entry

Issue implementation guidance, monitor discrimination, provide counselling, enable flexible learning and assess attendance, progression and completion rather than enrolment alone.

### 6.3 Expand Confidential Adolescent-Responsive Services

Train providers in adolescent communication, informed consent, safeguarding and contraception; improve privacy; and extend outreach in rural and underserved communities.

### 6.4 Strengthen Comprehensive Sexuality Education

Address consent, coercion, contraception, healthy relationships, gender equality and service navigation, while equipping parents for accurate and non-judgemental communication.

### 6.5 Enforce Child-Marriage and Protection Laws

Improve registration, reporting, safeguarding and accountability without criminalising or further marginalising pregnant adolescents.

### 6.6 Engage Boys, Men and Community Leaders

Include boys and men as accountable participants and support traditional and religious leaders to advance delayed marriage, education and non-violent gender norms.

### 6.7 Integrate Institutional Responses

Establish coordinated referral and case-management protocols among schools, clinics, social-welfare services and child-protection structures.

### 6.8 Strengthen Future Research

Include adolescent fathers, male partners, girls who have not experienced pregnancy, adolescents with disabilities and diverse rural, linguistic and religious communities. Use longitudinal and participatory designs.

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