

RESEARCH

Improving access to sexual and reproductive health services among adolescent women in Zimbabwe

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Abstract

Background: Unplanned pregnancies increased among adolescents in Zimbabwe, resulting in unsafe abortions, sexual and gender-based violence, and forced marriages. Access to Sexual and Reproductive Health and Rights (SRHR) has been scanty among pregnant adolescents and adolescent mothers owing to negative social norms, stigma and discrimination. This project specifically targeted pregnant adolescents and adolescent mothers through a differentiated and targeted care approach to improve uptake and sexual and reproductive health outcomes.

Methods: Target-specific peer support groups for pregnant adolescents and adolescent mothers were established in Epworth district of Zimbabwe. The Champions of Change, a peer-based approach, was used to facilitate comprehensive sexuality education. Mentors were adolescent mothers trained on how to use a tailor-made manual to facilitate sessions. Two health centers, namely Epworth Clinic and Overspill Clinic, were purposively selected to participate in this study. A total of 60 participants were recruited into this study, 30 from each clinic. Knowledge and attitude were measured using a semi-structured questionnaire administered before and after the intervention. A scorecard was used to assess friendliness and quality of service provision. A Chi-square test of association was used to determine the significance of the change in outcomes.

Results: A significant improvement in knowledge of SRHR, attitudes, and healthcare-seeking behaviors was noted. There was a significant improvement in attitudes and friendliness in service provision. Access to services significantly increased with improvements in relationships and trust.

Conclusion: A targeted and differentiated care approach increases the uptake of services and health outcomes among adolescent women by addressing their unique needs and circumstances.

Lay summary

Adolescent pregnancy and motherhood have significantly risen in Zimbabwe with the advent of the COVID-19 pandemic. The condition of these adolescent women has been worsened by poor access to and utilization of sexual and reproductive health services by this unique group, resulting in poor sexual health outcomes. Pregnant adolescents and adolescent mothers are less likely to access sexual and reproductive health services due to heightened stigma and discrimination by peers, communities and service providers themselves. We adopted a

peer-based approach to increase the agency of adolescent women and empower them through comprehensive sexuality education, engaging healthcare service providers, and improving parent-child communication. With our intervention, we noted a significant improvement in the proportion of pregnant adolescents and adolescent mothers accessing services and reporting improvement in relationships with parents and healthcare providers. We encourage health providers to consider providing targeted services to this group to improve uptake and health outcomes.

Keywords: access; adolescent-mothers; peer-based approach; services

Introduction

Sexual and reproductive health remains a critical determinant of the quality of health and life of adolescent girls and young women (AGYW) globally. In Zimbabwe, unintended and unplanned pregnancies among AGYW remain unacceptably high. Such pregnancies are a key driver of child, early and forced marriages and unions (CEFMU), which have ultimately fueled an increase in the incidence of sexual gender-based violence (SGBV). Nationally, 4.2% of adolescent girls are married before the age of 15 years and 32% of girls in Zimbabwe are married before the age of 18. According to the multiple indicator cluster survey (MICS) of 2019, the adolescent birth rate is eight times higher in women with primary education than those with higher education, and four times higher in women from the poorest households than those from the richest households (Zimbabwe National Statistics Agency 2020). The same study reported that about one in three (34%) of women aged 20–24 are first married or in union before age 18, which is a clear indication of the high prevalence of CEFMU.

An increase in unintended and unwanted pregnancies among AGYW has been experienced as a result of the COVID-19-induced lockdown, increasing exposure to SGBV cases and CEFMU. The COVID-19-induced lockdown in Zimbabwe increased the incidence of CEFMU and SGBV due to several factors. Economic hardships exacerbated by the lockdown pushed families to marry off young girls for financial relief. School closures left girls more vulnerable to exploitation and reduced their access to education and support systems. Additionally, confinement at home increased exposure to abusive environments, with limited access to reporting mechanisms and support services. The lockdown also strained community and social networks that typically offer protection and intervention for vulnerable children and adolescents. Access to sexual and reproductive health and rights (SRHR) and SGBV services for AGYW remains restricted, owing to negative social norms, poor parental-child communication, poor attitudes and low capacity of service providers to provide youth-friendly and gender-responsive SRHR and SGBV services to adolescents.

Pregnant adolescents and adolescent mothers constitute a unique group; they cannot easily fit into peer groups of adolescents who are not pregnant or married and at

the same time, cannot fit into the groups of older women and end up failing to access SRHR and SGBV services due to stigmatization and discrimination. A pregnant adolescent in low-income countries is likely to be chased away from home and married off, resulting in a high incidence of child marriages and child-parenthood. Countries differ with regard to their policies on access to services for adolescents, with conservative countries like Zimbabwe restricting access to sexual and reproductive health services (SRH) to the age of 18 years, which is the age of consent for marriage, sex and accessing services.

Very few interventions globally have sought to understand the plight of pregnant adolescents and adolescent mothers with regard to their sexual and reproductive health outcomes, yet scientific evidence proves that adolescent mothers are more likely to be poor and perpetuate child poverty. In Zimbabwe, one in every four maternal deaths is an adolescent mother (Zimbabwe National Statistics Agency 2014). Adolescent motherhood has also been proven to result in high infant morbidity and mortality, especially low birth weight and pre-term birth. Our study piloted a peer-based approach to empower adolescent women (pregnant adolescents and adolescent mothers) to improve their knowledge, agency and access to sexual and reproductive health services in Zimbabwe through an integrated approach that brings together adolescent women, their parents and healthcare providers.

Epworth is a densely populated urban poor town situated 12 km to the South-East of Harare, the capital of Zimbabwe (Msindo *et al.* 2013). It has a population of 206,368 people spread over an area of 35.35 square km and with a population density of 5,837 per square km (Zimbabwe National Statistics Agency 2014). The area is characterized by incomplete roads, unstructured houses made of unfinished bricks, unsafe water, no electrified houses, no sewage system and poor toilets. Epworth is characterized by poverty, drug-infested and law-breaking residences, as well as a high prevalence of child marriages. Almost half of all teenage girls in Epworth are married due to poverty. Due to poor access to sexual and reproductive health services for teenagers, unintended and unwanted pregnancies are highly prevalent (Zimbabwe National Statistics Agency 2014).

According to the Mid-Term Evaluation (MTE) for the Swedish International Development Agency (SIDA) funded project, 'Promoting Inclusive access to SRHR and SGBV information and services in Zimbabwe', conducted by Plan International in 2020, 29% of adolescents and young people (AYP) aged 10–24 years in Epworth do not know what SGBV is. The same report revealed that domestic violence, rape within the family and rape by a stranger were the most highlighted violations. Only 54% of SGBV survivors aged 10–24 accessed SGBV services, against a national target of at least 90%. The national gender-based violence (GBV) Hotline recorded a total of 5306 GBV calls from the beginning of the lockdown on 30 March until 7 October 2020. This number represented a 60% increase in cases when compared to the pre-lockdown statistics ([Global Protection Cluster 2021](#)). Of the GBV cases recorded during the COVID-19 pandemic in Zimbabwe, psychological and physical violence constituted 22% of total cases, economic violence (15%) and sexual violence (8%). About 90% of all the GBV cases were intimate partner violence (Zimbabwe Cluster Status: Protection-GBV 2021). Deep-rooted and pervasive gender inequalities and sexual violence are also responsible for the high and accelerated prevalence of HIV among AGYW ([Plan International 2020](#)). Our study sought to evaluate the capacity of a peer-based approach to significantly improve access and utilization of SRHR and SGBV services and sexual and reproductive health outcomes for pregnant adolescents and adolescent mothers in the Epworth district in Zimbabwe.

Materials and methods

This study hypothesized that direct targeting of pregnant adolescents and adolescent mothers would improve their sexual and reproductive health outcomes. A before and after descriptive cross-sectional study design was employed to assess the influence of a social behavior change mobilization intervention package on SRH outcomes.

The study introduced target-specific peer support groups for pregnant adolescents and adolescent mothers from the catchment area of Epworth Clinic and Overspill Clinic in Epworth district. Pregnant adolescents and adolescent mothers who were recruited into two open cohorts (one for Epworth Clinic and the other one for Overspill Clinic) using consecutive sampling. Education on sexual, reproductive, and maternal health was facilitated through a peer-led approach (Champions of Change model) over a period of 6 months (1 January 2022 to 30 June 2022). The Champions of Change approach aims at advancing gender-responsive sexual and reproductive health programming through the implementation of a modularized empowerment program for adolescent girls and boys. In our study, the approach was tailor-made to focus on pregnant adolescents and adolescent women only.

In our study, we developed a tailor-made manual that had short modules on comprehensive sexuality education, maternal and child health and positive parent-child communication. Mentors were adolescent mothers who received a 10-day training on how to facilitate the sessions for their peers using participatory approaches. The local nurses at Epworth Clinic and Overspill Clinic facilitated technical sessions and supervised club activities. Club sessions were held once per week for 2 h at the respective clinics. The club members had an opportunity to ask nurses questions and to bring out their concerns and recommendations for the provision of quality, friendly and gender responsive services in the two clinics. Parents of the participating adolescents were engaged by project officers in positive parent-child communication on a monthly basis. The aim of the intervention was to improve access to information and services on SRHR and SGBV among pregnant adolescents and adolescent mothers in the Epworth District.

Specific objectives

- i. To increase knowledge on SRHR among pregnant adolescents and adolescent mothers in the Epworth district by October 2022.
- ii. To increase access to adolescent-friendly services among pregnant adolescents and adolescent mothers in the Epworth district by October 2022.
- iii. To improve reporting and access to SGBV response services among pregnant adolescents and adolescent mothers affected by gender-based violence in Epworth district by October 2022.
- iv. To increase the proportion of pregnant adolescents and adolescent mothers who report positive attitudes to adolescent sexual health in Epworth by October 2022.

Target population

Pregnant adolescents and adolescent mothers in the Epworth District.

Key stakeholders

The key stakeholders in this project were pregnant adolescents and adolescent mothers, parents, community leaders and service providers/line ministries (Ministry of Health and Childcare, Ministry of Women Affairs Gender and Development). The project also worked with implementing partners in SRHR and SGBV, and included JF Kapnek (disability programming in SRHR), Katswe Sistahood (SGBV), Population Services Zimbabwe (PSZ) (mobile outreaches for SRHR service provision), Childline (SGBV survivors therapeutic support groups) and the Zimbabwe National Family Planning Council for family planning services and peer education. The human-centered design approach was employed to enable the pregnant adolescents and adolescent mothers

in the Epworth district to be at the center of their own sexual reproductive health through participating in rapid needs assessment, interim review meetings and feedback sessions with health care providers. They also participated as learners and peer facilitators in peer-based support groups specifically targeting pregnant adolescents and adolescent mothers. Nurses, nutritionists and community health care workers were engaged as experts and direct supervisors of the project interventions for sustainability. The Ministry of Women Affairs, Gender and Economic Development educated the clubs on matters of gender and SGBV and the Ministry of Youth facilitated sessions on economic empowerment initiatives.

Measurements

The project employed a peer-to-peer approach to promote internal learning and perpetuation of best practices among club members through look-and-learn visits and joint quarterly review meetings. In review meetings, the pregnant adolescents and adolescent mothers gave each other testimonials and reflected on what was working and what could be improved to enhance their learning and access to services. The charge nurses also met with the club members quarterly to reflect on the quality of SRHR and SGBV services and how they can be responsive to their needs. Scorecards were also used by club members quarterly to give feedback to healthcare staff on their performance against the quality standards for youth-friendly and gender-responsive service provision.

To assess parents' attitudes towards adolescents accessing SRHR and SGBV services, we administered a short questionnaire that assessed attitudes by asking simple questions to adolescents on how they perceive their parents' attitudes on accessing contraceptives (both short-term and long-term), accessing counseling services on SGBV, among other things (Supplementary data, see section on [supplementary materials](#) given at the end of this article).

A scorecard was used to assess youth friendliness before and after intervention. The adolescents evaluated service delivery by giving a score on different domains of friendliness, such as timeliness of service, affordability, availability, acceptability, service provider attitudes and other domains. A score of 80% and above was rated as a friendly service provision.

To assess the knowledge change, a simple questionnaire with questions on sexual and reproductive health rights, services available in the community and at the health facility and family planning methods was used (Supplementary data). Participants with an overall score of 80% or higher were considered to have knowledge of sexual and reproductive health.

Institutional records were used to determine access to SGBV services. A participating adolescent who had

accessed at least one SGBV service, such as counseling services, initiation on post-exposure prophylaxis and others was considered as accessing services. Attitudes of the adolescents were assessed by asking the participants for their opinions on the use of different modern contraceptive methods in preventing unintended pregnancies.

Analysis and results

Socio-demographic characteristics of participants

The study had a total of 60 participants; 40 (66.7%) were pregnant, and 20 (33.3%) adolescent mothers who were recruited for the study and their baseline and endline information on access to services, utilization and perceptions on attitudes and quality of sexual reproductive health service provision was assessed. Fifty percent of the participants were from Epworth Clinic, and the other 50% were from Overspill. Of the 60 participants, 12 (20%) were in the age range of 10–15 years and the rest were 16–19 years old. Most of the participants (50%) belonged to the African Apostolic religion and most of the participants were cohabiting. Half of the participants had reached secondary-level education. The mean age of the study participants was 17.2 years (s.d. = 1.58). [Table 1](#) below summarizes the socio-demographic results of the participants.

Significance of change of outcomes before and after intervention

The study hypothesized that the intervention would have a significant effect on the sexual reproductive health outcomes of pregnant adolescents and adolescent mothers. Data entry and analysis were carried out in STATA 15. A chi-square test of association was used to test the statistical significance of the change at $P < 0.05$. Study results revealed a statistically significant difference in the proportion of pregnant adolescents and adolescent mothers who reported improved attitudes of parents and service providers on adolescent reproductive health. Results also showed a significant change in the knowledge, attitudes and access to SRHR and SGBV services. [Table 2](#) below summarizes the results on the significance of the association between baseline and endline results.

Discussion

This study sought to evaluate the effectiveness of the adopted Champions of Change approach in improving sexual and reproductive health outcomes of pregnant adolescents and adolescent mothers in the Epworth district of Zimbabwe. Sixty participants were recruited

Table 1 Socio-demographic characteristics.

Variable	Count (%)
Age, years	
10–15	12 (20.0)
16–19	48 (80.0)
Maternal status of adolescent	
Pregnant	40 (66.7)
Adolescent mother	20 (33.3)
Religion	
Protestant	12 (20.0)
African Apostolic	30 (50.0)
Catholic	10 (16.7)
Other	8 (13.3)
Marital status	
Married	15 (25.0)
Unmarried	10 (16.7)
Divorced/separated	5 (8.3)
Co-habiting	30 (50.0)
Education	
None	5 (8.3)
Primary	15 (25.0)
Secondary	30 (50.0)

and received the intervention package and outcomes were reassessed at the end of the project.

The mean age of the participants was 17 years. This would mean that the majority of the adolescent girls were getting pregnant and becoming mothers at an age earlier than 18, the general age of consent in Zimbabwe. This clearly shows that policymakers still need to conduct further analysis on the implications of clustering the age of consent for marriage, sex and accessing services at 18 years. Several studies have shown that where the age of consent to accessing services is higher, adolescent girls face more adverse sexual and reproductive health outcomes, which include unsafe abortion.

Fifty percent of the participants belonged to the African Apostolic religious groups, and more than a third

had not reached the secondary level of education. In Zimbabwe, most of the apostolic religious groups are very conservative with regard to the use of modern medicine and health facilities. This could explain why the uptake rates for services were very low at baseline. The significant improvement in the utilization of services could point to the power of the peer-based approach in harnessing social capital towards positive health-seeking practices as these adolescent women learn from each other's experiences and devise mechanisms of accessing services like contraception. With the advent of the educative session on family planning methods and how they can prevent unwanted pregnancies, our study realized an increase in the uptake of long-term reversible contraceptives such as implants by these adolescent women.

Our study results were consistent with the findings of other studies in lower to medium-income countries. Similar to the situation in Zimbabwe, the uptake of sexual reproductive and maternal services by pregnant adolescents in Uganda is very low, standing at 41.1% (Cumber *et al.* 2022). A qualitative study conducted by (Cumber *et al.* 2022), revealed that pregnant adolescents face financial challenges and health facility access challenges. Interviewed adolescents cited discrimination by health workers and a lack of privacy when receiving services as major barriers to accessing maternal health services. The study recommended improved working conditions and the acceleration of community and health worker awareness to mitigate barriers.

A similar qualitative study was conducted in South Africa on pregnant mothers' experiences with healthcare workers. The study concluded that the way pregnant adolescents are treated at antenatal clinics influences their timely utilization of services. Pregnant adolescents and adolescent mothers reported negative experiences which included victimization; discrimination against being pregnant at a young age; experiencing disregard and exclusion; inadequate provision of information about pregnancy, health and childbirth; clinic attendance discouragement; and mental health turmoil (Sewpaul *et al.* 2021). This has always been associated with poor

Table 2 Baseline and endline results.

Indicator	Baseline (n = 60)	End-line (n = 58)	% change	Chi-square P
Pregnant adolescents and adolescent mothers aged 15–19 reporting improved attitudes among parents on ASRHR	14 (24%)	38 (66%)	42	0.001*
Pregnant adolescents and adolescent mothers accessing adolescent-friendly SRHR services	20 (33%)	44 (76%)	43	0.001*
Adolescents reporting improved SRHR knowledge	38 (63%)	52 (90%)	27	0.012*
Pregnant adolescents and adolescent mothers affected by gender-based violence accessing GBV reporting and response services	12 (20%)	25 (43%)	23	0.023*
Pregnant adolescents and adolescent mothers with a positive attitude towards the use of long-acting reversible contraceptives	42 (70%)	55 (95%)	25	0.019*

*represents statistically significant association.

service uptake and negative sexual and reproductive health outcomes in the key target group.

In this study, results showed similar trends that good interpersonal relationships between healthcare service providers are instrumental in promoting consistent uptake of healthcare services by adolescent women. Pregnant adolescents and adolescent mothers are sensitive to the attitudes of service providers and cherish privacy and confidentiality in receiving targeted health services. They are sensitive to the environment of care, and it is important for institutions to engage these adolescent women on their needs and expectations if the health system is going to have a positive impact on their health outcomes.

A phenomenological study conducted by [Bwalya *et al.* \(2018\)](#) on the experiences of pregnant adolescents during ANC revealed a gap in the friendliness of service provision, poor attitudes and behaviors by the older pregnant women and health providers. Opening hours were deemed unfavorable to all adolescents, and lack of specific spaces for adolescents, as well as inadequate privacy and confidentiality, were reported as barriers. The study recommended reducing waiting hours for consultations and establishing specific rooms or spaces for pregnant adolescents at the clinic. The study also recommended appropriate interventions targeting pregnant adolescents with an emphasis on making services more friendly.

In our study, we also got the impression that the attitudes of both parents and health workers were critical determinants of service access and health outcomes. We observed an improvement in the relationships between parents and pregnant adolescents and adolescent mothers. Healthy parent-child communication and positive parenting for this unique group of adolescents improve their trust and cooperation and ultimately enhance their maternal and sexual reproductive health outcomes by reducing the incidence of depression, self-blame and denial, suicidal cases and cases of unsafe abortions. These have been the leading causes of maternal morbidity and mortality among pregnant adolescents and adolescent mothers.

A similar study in Namibia revealed that long traveling hours to the nearest health center, worsened by poor support with transport fare, poor road infrastructure and non-availability of transport were key barriers to service access. Other barriers pertained to family dynamics, such as disclosing the pregnancy to family members prior to commencing antenatal care (ANC) visits and harsh treatment from family members after the disclosure ([Shatilwe *et al.* 2022](#)). Our intervention addressed parental attitudes through open communication. This ultimately resulted in pregnant adolescents and adolescent mothers opening up about modern contraception. We realized a significant increase in the proportion of adolescent mothers who were voluntarily choosing to use long-term reversible contraceptives such as implants following open discussions with parents and

healthcare providers on family planning methods and the importance of birth control to adolescent mothers.

A study conducted in South Africa concluded that, despite high levels of antenatal clinic attendance among pregnant adolescents in KwaZulu-Natal, the mother to child transmission (MTCT) risk is higher among infants of HIV-infected adolescent mothers compared to adult mothers. Access to adolescent-friendly family planning and prevention of mother to child transmission (PMTCT) services should be prioritized for this vulnerable group ([Horwood *et al.* 2013](#)). It is clear that there is a great need to use different approaches and segment services provided to women of childbearing age, considering the factor of age.

This project established community structures that will serve as a vehicle for project continuity beyond the life span of the project. The Champions of Change groups will continue to provide essential support to their respective communities after the project. Ministries of Health and Child Care and Ministry of Women Affairs' structures at the district and community level will continue to support the clubs as they have been actively participating in the functionality of the clubs. The Zimbabwe Family Planning Council (ZNFPC) has been engaged and is already considering further training for the mentors and adopting them as part of their pool of peer educators to continue implementing the targeted approach. The project has established and strengthened an adolescent sexual and reproductive health (ASRH) committee at Epworth and Overspill clinics, which will also include adolescent parents and young people to enhance their continued participation and planning of SRH-related initiatives in clinics. The ASRH committee will spearhead the institutionalization and operationalization of quarterly YFS reviews and feedback sessions with support from the Ministry of Health and Child Care and Zimbabwe National Family Planning Council (ZNFPC), ensuring continued quality service provision.

Study limitations and strengths

The sample size for our study was relatively smaller than what would be required for the generalization of the study findings, making it difficult to establish causality or assess changes over time in access to SRH and SGBV services. Similarly, we used self-reported perceptions of the participants, which increases the chances of social desirability bias. It was somewhat challenging to measure qualitative aspects of service access, such as the quality of care and the attitudes of healthcare providers, using a descriptive approach. Future studies can consider using a mixed methods approach with a larger sample to triangulate data and get a clearer picture of the subject matter. The challenges that we also faced in implementing the study included negative socio-cultural norms and religious beliefs that strongly condemn the teaching of comprehensive sexuality education and the provision of SRH services to perinatal adolescents,

which is often viewed as promoting promiscuity in this group of adolescents.

The strengths of the study included harnessing the power of social immersion to gain trust from the target group, which improved the likelihood of getting genuine and truthful responses from participants, as trust had been built over a significant period of time. The study employed collaborative and participatory approaches that resulted in the target population, parents and health care workers owning the project. This increases the chances of sustaining the gains of the project.

Conclusion

This study sought to improve access to SGBV and SRHR services among pregnant adolescents and adolescent mothers through the implementation of a peer-based approach, the Champions of Change model. We then compared selected SRHR indicators before and after the implementation. The intervention resulted in significant positive SRH outcomes among the targeted populations. We conclude that the use of peer-based approaches to empower adolescent women increases their knowledge, attitudes, agency and adoption of positive practices in sexual reproductive health and improves communication and support from both parents and healthcare service providers.

Supplementary materials

This is linked to the online version of the paper at <https://doi.org/10.1530/RAF-24-0008>.

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the study reported.

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Author contribution statement

MM: development of the original draft. AM: review of the manuscript, data analysis and discussion. JK: review of the manuscript, data analysis and discussion. TY: review of the manuscript, data analysis and discussion.

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