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"The ones at the bottom of the food chain": structural drivers of unintended pregnancy and unsafe abortion amongst adolescent girls in Zambia

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Abstract

Background Access to safe abortion care is highly unequal and fundamentally rooted in socioeconomic inequalities which are amplified by restrictive social norms and legal systems. We analyse these inequalities along the reproductive health continuum amongst adolescent girls in Zambia.

Methodology This paper draws from 20 focus group discussions conducted in 2021 with community members (young/adult) in five urban, peri urban, and rural sites in Zambia. Data was analysed using thematic analysis.

Results Adolescent pregnancy in the community was reported to be very common across the communities with girls from poorer families being disproportionately affected. Parents were reported to be complicit in facilitating their daughter's sexual-economic exchanges which emerged as a key driver of pregnancies. Young age and unmarried status meant adolescent girls could face triple stigma: stigma around accessing contraception to prevent a pregnancy, stigma in experiencing an unintended pregnancy and stigma around terminating an unintended pregnancy. There were clear socioeconomic differences in adolescent girl's exposure to community and health provider censure and/or acceptance of their pregnancy, and in their ability to conceal an abortion. Having the means to pay for health care allows some adolescents to seek terminations earlier and to access private health facilities while poorer adolescent girls face greater exposure to community censure through their embeddedness within the community. Abortions in this group attracts greater visibility through complications arising from their constrained choice for safe abortion methods. Stigmatising attitudes of community members also undermined adolescents' reproductive agency and mental health. For adolescents who choose to keep an unintended pregnancy, reintegration into school was highly challenging despite a national policy in place, with marriage being viewed as the only future option for poorer teenage mothers.

Conclusion The embeddedness of adolescent pregnancies within community structures of economic insecurity and gendered and age-related power relations highlight the importance of introducing community level approaches to tackle unintended pregnancies and unsafe abortion. Understanding teenage pregnancy as a community issue creates opportunities for community level support to young girls especially when they return to school.

Keywords Unintended pregnancy, Unsafe abortion, Adolescent girls, Zambia

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Text box 1. Contributions to the literature

- Risk factors for adolescent pregnancy are often explored at the individual level while it is an issue embedded in community contexts.
- In contexts with high economic insecurity, parents and community members can play a key role in enabling a girl child's participation in sexual-economic exchanges which can result in unintended pregnancy. However, pregnant adolescent girls often face personal stigma, discrimination and other negative consequences from their family and community.
- Efforts to reintegrate adolescent mothers in school need to consider disruptions to academic trajectories brought about during pregnancy and account for the physical demands of caring for an infant.

Introduction

While there has been significant progress in reducing maternal mortality globally, high unmet need for family planning/contraception and adolescent birth rates persists in Africa. Compared to other regions, Africa's adolescent birth rate in 2020 was the highest (102.1 per 1000 women aged 15–19 years) and more than twice the world's average of 42.1 [35]. Complications in pregnancy and childbirth are the leading cause of maternal mortality amongst girls (15–19 years) [36]. In low- and middle-income countries (LMICs), half of pregnancies amongst adolescents (15–19 years)[1] are unintended and 55% of unintended pregnancies end in abortions, which are frequently unsafe [30]. Not only is adolescent pregnancy a major contributor to adolescent maternal mortality and morbidity, it also disrupts childhood and schooling trajectories and perpetuates intergenerational cycles of ill-health and poverty [24, 34]. Young women (including adolescent girls) with no or low education and in the lowest wealth quintile are disproportionately burdened with early childbearing [2, 7] with wide regional differences [28]. Wealth inequalities are also known to affect access to safe abortion care, with women and girls who are poorer and of lower socioeconomic class disproportionately disadvantaged [4, 37].

Adolescent girls in Zambia, like in many other LMICs, experience numerous SRH challenges [21]. The 2018 Zambia Demographic and Health Survey found that 29% of adolescents aged 15–19 years had already begun childbearing, with teenagers living in rural areas more likely to have begun childbearing than those living in urban areas (37% versus 19% respectively) [38]. Many contextual factors impede their access to SRH services. Poverty, myths and community and social norms regarding SRH services such as contraception, limited availability of adolescent friendly services have been reported to contribute to early childbearing [21, 40]. Religious values and conservative norms also negatively affect adolescent access to SRH services. Since the country's Independence in 1964, Zambian society has been characterised by predominantly conservative Christian values, with 95.5% of the population identifying as Christian (Zambia 2019 International Religious Freedom report). A reaffirmation of this position occurred in 1991 when Zambia was explicitly declared as Christian nation, and, in 1996, when this qualifier was included in the preamble to the Constitution of the Republic of Zambia itself.[2]In present day Zambia, the nation's Christian identity strongly shapes "dominant discourses on morality, sexuality and reproduction" [12], p 6). This is contrasted with the fact that Zambia is one of the few African countries with a legal context in which Termination of Pregnancy (TOP) can be requested on health and socioeconomic grounds.[3] However, access to safe abortion care is, in practice, highly restricted by the procedural requirements stipulated in the TOP Act in order to be granted an abortion, as well as multiple health system and sociocultural barriers. Unsafe abortion is one of the top five causes of maternal mortality in Zambia [11].[4] Moreover, earlier studies have shown that the burden of costs for unsafe abortion care was found to be highest for poorer women in Zambia [17, 27].

Despite the existence of policies to ensure provision of contraceptives and safe abortion services to adolescent girls, access to and uptake of these services remains a challenge in Zambia with young girls disproportionately burdened by unintended pregnancies [22, 29]. Understanding the contexts in which adolescent pregnancies occur are important for intervention design. In particular, an understanding of the structural and institutional factors that shape girls' agency to make reproductive health choices and decisions is required. This paper presents a sub-analysis of a qualitative study aimed at understanding the political economy of access to safe abortion care in Zambia. Specifically, this paper presents an analysis of the community-level data which offers understanding of the community views on adolescent (10–19 years) pregnancies and abortion and insight into the underlying

[1] According to the World Health Organization "adolescent pregnancy" means pregnancy in a woman aged 10–19 years. (World Health Organization. Adolescent pregnancy. World Health Organization, 2004. https://iris.who.int/bitstream/handle/10665/42903/9241591455_eng.pdf).

[2] See Haaland et al. [12] for an excellent analysis of the historical socio-political context within which the Zambian Termination of Pregnancy Act emerged.

[3] Abortion is regulated by the TOP Act of Chapter 26 of 1972 and chapter 13 of 1994 of the revised Act in Zambia. Please see the Addendum for specific provisions of the Act.

[4] Maternal mortality ratio was estimated at 252/100, 000 live births and approx. 30% of the mortality is as result of unsafe abortions of which 80% occur among adolescents [39].

dynamics and contexts in which adolescent pregnancies and unsafe abortions occur.

Methodology

The study was conducted in 2021 and included 20 focus group discussions with community members from five study sites across three Provinces in the country. We selected districts within the Western, Lusaka, and Eastern Provinces and allowed for a selection of urban (Lusaka, the capital and largest city, peri urban areas and Mongu, the provincial capital city of Western Province and Chipata, the provincial capital city of the Eastern Province), and rural sites (Kaoma District in Western Province and Petauke in Eastern Province) across the breadth of the country.

In each study site, community members were recruited through neighbourhood health committees, local NGOs/CBOs for the purpose of focus group discussions (FGDs). We used these structures to recruit the participants due to sensitivity of the subject. We purposely selected community members who had stayed in the community for more than 5 years and could share views on unintended adolescent and adult pregnancies, and on abortion as well as on the influence of the family, partner and community on the decision-making process around an unintended and unwanted pregnancy. Participants were grouped according to age (either 18–24 years or > 24 years) and sex (male or female). The FGDs were conducted at community level, and only those residing within the same community participated with a minimum of five and maximum of 10 individuals in each focus group discussion. Using a topic guide, the discussion sought to explore community views on unintended adolescent and adult pregnancies, and on abortion as well as on the influence of the family, partner and community on the decision-making process around an unintended and unwanted pregnancy. Abortion provider preferences (public/private, formal/informal) were also explored in the FGDs. FGDs lasted between 1.5 and two hours and were conducted in the language of the region (Nyanya/Bemba in Lusaka Province and Eastern Province, Lozi in Western Province). The interviews were then transcribed and translated into English.

Data analysis

The FGDs were recorded digitally and later transcribed verbatim. Thematic content analysis, following key concepts in the study and emerging themes and subthemes, was employed in this study, as laid out by Corbin and Strauss [9]. The use of a priori themes for the development of qualitative data collection facilitated analyses across the FGD transcriptions. To enhance reliability and consistence during the data analysis process, the transcripts were independently reviewed by the authors. We first started the analysis process by developing a coding framework. Focus group data were then coded independently by two of the research team members (TC and CA), using NVivo software. To further promote quality or reliability of the themes, all the authors participated in the process of interpreting and refining the themes in data processes. The themes focused on experiences of unintended adolescent pregnancies, abortion as well as on the influence of the context on the decision-making process around an unintended pregnancy and abortion.

Ethical considerations

Ethics approval for the study was obtained from the Human Social Sciences Research Ethics Committee, University of KwaZulu-Natal in South Africa, APHRC Institutional Review Board, in Kenya and by the National Health Research Authority, and the IRB of Excellence in Research Ethics and Science (ERES) Converge in Zambia. All participants provided written informed consent and were informed of the voluntary nature of the study and possibility to opt-out of the study at all times. The FGDs took place in locations convenient to the participants and where their privacy and confidentiality could be maintained. Due to the sensitive nature of the topic, the research team employed several strategies to further safeguard privacy and confidentiality. Digital recordings and transcribed data were stored on a single password protected hard drive and a password protected back-up drive while all hard copies (such as consent forms and researcher notes) were kept locked in a secure cabinet in the office of the researcher in Zambia (JZ).

Results

The gender, poverty and sexual-economic exchange nexus

Adolescent pregnancy in the community was reported to be very common by participants across age and gender groups, and study sites. A number of reasons were offered to explain the high rates of adolescent pregnancies including the cultural practice of puberty initiations and sexual experimentation, adolescent girls wanting to demonstrate fertility, parental neglect or young girls reportedly "not listening" to their parent's advice, and limited access to and stigma around accessing contraceptives especially if they are under the age of 18 years as described by one of the participants:

If I go and am found with condoms, there is "she likes

to sleep around, she's not well behaved" so instead when you go and try to prevent pregnancy from the clinic - or anywhere, the service providers more so, if it is a community clinic like a local clinic, I don't go to my community clinic because there I am known by everyone there, my parents are known the daughter of this and that came to get condoms before you know it, it's the talk of the town. Even in my house, I am 22 but scared of my mum finding me with condoms then it's going to be the talk of the family. (Female FDG, 18-24 years, Lusaka)

While some participants felt that adolescent girls from both rich and poor families equally experienced unintended pregnancy, many others linked adolescent pregnancy to poverty and food insecurity.

I think [it is] the ones at the bottom of the food chain. The ones that live in rural areas and the ones that live in compounds who experience teen pregnancy more. The ones that are mistreated, like those kids who do not really have access to finances, like we said poverty, and they might get into relationships or maybe make connections with people that would give them money for sex. (Female FGD, 18–24 years, Lusaka).

You are going to find that most of the people staying in this village are poor, so as a result they involve themselves in sexual activities, so that they can have money from different guys and may end up getting the pregnancy. That is again the major cause of teenage pregnancy in our community. (Male FGD, 18-24 years, Petauke)

These transactional sexual relationships were repeatedly raised in the FDGs across the sex and age groups. Parents living in rural areas were also often mentioned as being complicit or actively encouraging these transactional relationships with older men, who were often parents themselves, and were identified as being involved in these relationships. These observations were shared by participants in both urban and rural areas:

Because most of them are ignorant and illiterate, the [parents] do not understand the consequences of sending a girl out there to look for money. They think since the girl has started her menstrual period she is grown and it's time for them to take care of the family through enticing rich men out there. We have so many women doing that in the community, on a daily basis we see them. (Male FGD, >24 years, Mongu)

They receive the money from their child without questioning where the money came from. In such a situation it is difficult for a parent to react if the child ends up being pregnant because they know that the money they used to get came from men and definitely they were given that money in exchange for sex. Such parents do nothing because they knew what was happening from the beginning. (Male FGD, 18-24 years, Kaoma)

Importantly, all ages of participants (including parents participating in the FGDs) spoke of the role of parents in these transactional exchanges, with parents often blaming the opposite gender, namely mothers for pushing their daughter into transactional sex and fathers for having transactional sex with girls:

I think the main reason why these girls get pregnant is poverty. Apart from that I will blame their parents, especially the mothers, because they are the ones who force them to go out and look for food to feed the family. Meanwhile the parents are just sitting at home and doing nothing. These girls will take the responsibility of taking care of the family at a tender age and the only way they can manage that is by going out with people who have money who will in turn demand for sex. It's a barter system happening. (Male FGD, > 24 years, Mongu)

What causes children to fall pregnant? Sometimes our children admire too much. You will find that the friend at school is having money every day and she will be telling her that me I go out with my sugar daddy, so she will also find a sugar daddy to give her money and that results in them getting pregnant. And again the male parents in the community, these known as sugar daddies, have destroyed our children because they start having affairs with our young girls. (Female FGD, > 24 years, Chipata).

The data also highlighted barriers for adolescent girls to access contraception, including fear of side effects, lack of knowledge about contraception or where to obtain them, as well as judgemental or questioning attitudes by health care providers and shyness of girls in accessing these services:

Participant 1: For those people who are above 18 years, it's very easy for them to go to the clinic to access contraceptives, like injections, as compared to those that are 16 years and below because they are afraid of stigma at the clinic and for them to access injections for three months it will be difficult. That's the reason they fall pregnant most of the time.

Participant 5: It's very difficult for young people to

access the contraceptives in a clinic because when they go there they will be asked why they want them, and ask about their age, so these things actually discourage them from going there. We had a situation where the girl, after having sex with the boy, took about 18 panadol's just to avoid the pregnancy, so this shows the gap in information. (Male FGD, >24 years, Lusaka)

Participants also cited resistance from parents in supporting girls' access to contraceptives as a barrier in accessing contraceptives services. Indeed, participants who were parents, and particularly fathers, shared their feelings of disapproval in contraception being provided to adolescent girls. These parents feared that should their daughter's take up contraception, they would lose the ability to control the sexuality of their child:

Participant 4: If I find injections or contraceptives with my child, I need to take a step in terms of trying to find out and advise her because those are signs that my child has stopped listening and she is engaging in sexual activities.

Participant 5: Sometimes as parents, we may not allow children to access injections and contraceptives but they will go on their own secretly to receive them. (Male FGD, >24 years, Chipata)

These circumstances caused some adolescent girls to use contraception clandestinely. The above transactional relationship dynamics, combined with challenges in obtaining contraception to prevent early and unintended pregnancies, provides some of the context in which teen pregnancies occur.

Consequences of unintended teenage pregnancies

There were a number of negative consequences for adolescent girls who experienced an unintended and early pregnancy and these were worse for girls who had less access to socioeconomic resources.

The nexus of stigma, abuse and mental health

Some community participants felt that adolescent pregnancies had become increasingly normalised, especially in rural or impoverished areas where it was widely viewed as common. However, most referred to the very negative repercussions for the adolescent girl and her family in these situations. Pregnancies were described as bringing shame and financial burden to the parents and that both the adolescent girl and her parents would be exposed to high levels of gossip and stigma from the community.

When a girl gets pregnant, they mock her, they use bad words such as a "prostitute", a disgrace, someone who has brought shame to her parents. Many bad words are used, some even insult the parents, but when you look at it, the parents aren't the ones who used to send her there but they will be insulted and laughed at together with their daughter. (Female FGD, >24 years, Kaoma)

Some parents will even stop their children from playing with that girl, because they are spoiled and they are termed as stubborn, prostitutes who never listen to elders. They will say don't play with that girl because she will teach you bad manners. To some extent even the parents will be blamed for being irresponsible. Because of all this, most of them will feel out of place because the environment will not be conducive enough for them. (Male FGD, 18-24 years, Mongu)

More specifically, church spaces were frequently identified as making an example of pregnant adolescents by excluding them from their positions in church and contributing to their feelings of shame and community stigma. Adolescent pregnant girls were reported to suffer exclusion and extreme discrimination including being removed from or dropping out of school, facing abuse, violence or rejection from family members as well as high levels of community censure and ostracisation, all of which negatively impacted their mental health.

If there is a teenager who is pregnant in our community, they are treated more of an outcast, parents are obviously disappointed, friends will shun them, friends 'parents will not let them play with them so the majority of the time they are left alone. The church will disfellowship them, sometimes they even call meetings to express how disappointed they are. Usually, it's a very hard position to be in when the teenager is pregnant, they don't get the emotional or spiritual support they deserve. (Female FGD, 18-24 years, Mongu)

In addition to the stigma and rejection, participants also shared that pregnant and parenting adolescent girls were expected to "woman up" and were left to fend for their needs and that of their baby. This is explained by one male participant:

The parents also change in the way they treat you, because they expect you to be more responsible for your child. They cannot manage to provide for your kid with everything, as a result they would want you to 'woman up' and do the needful. Life becomes difficult for those who decide not to abort. (Male FGD,

18-24 years, Mongu)

In part, the lack of parental support was linked to the unrealised financial investment in a girl's education, which had been disrupted by the pregnancy. The following male parent referred to parents as feeling "betrayed" by their child and being so enraged as to physically accost the child.

As a parent you have hope that this child will help you in the future and then she becomes pregnant. It's never good because maybe you will find that you had sold cattle just so that you pay for their school fees then they betray you in such a manner. You beat them as a parent. No parent wants to see their children pregnant. (Male FGD, >24 years, Kaoma)

A number of parents in the discussions spoke of the shame attached to a child becoming pregnant and the criticism they faced from the community for not teaching their children "good manners" and better behaviour. In one rural site, both the male and female participants above 24 years of age believed there was a need to physically discipline a pregnant adolescent and expressed frustration that while it was acceptable to hit a child in the past, it is no longer allowed because of risks of being reported to the authorities:

When a young girl falls pregnant, there is a lot of embarrassment. With the rule which has come… because our parents used to discipline us by beating us. Now with these children, they will say: "I am taking you to the police. I have rights!" So with these same rights the government has spoiled our children. If what our parents used to do can repeat itself. My parents used to beat me when I reached this age. Our parents used to tell us not to talk to boys. So I beg for the government that they must think twice over this human right because our children, we are failing to control them at home. (Female FGD, >24 years, Chipata)

Children nowadays don't want to listen to their parents, because of their rights. You find that the child will be coming home late and, in the end, you discover that she is pregnant. As a father you want to discipline that child and the mother will stop you to say she will take you to police. Such things have led to an increase in teenage pregnancies. The laws that the government has put in place stops us as parents to discipline our children, now the question is will the government be disciplining our children when we have failed as parents? (Male FGD, >24 years, Chipata)

Another participant shared an account of a pregnant adolescent whose mental health was so severely affected in the face of the potential consequences of her pregnancy that she had taken her own life:

Participant 5: I have a neighbour whose daughter fell pregnant in grade nine and she was told to stop school immediately without waiting for her to write her exams and she was told that she was going to be doing all the activities at home. She killed herself after she got pregnant because she was afraid of her uncle knowing about her condition, we knew about this from her aunt.

Interviewer: Why did she fear her uncle?

Participant 6: According to the information her uncle was very rough, he could beat. (Male FGD, 18-24 years, Lusaka)

Disruption in educational trajectories

Even if parents didn't force their daughters to stop attending school, young female participants across study sites shared that it was very difficult for pregnant girls to actually remain in school during their pregnancy because of the unwanted attention from their peers.

When your friend knows that you are pregnant, even when you just tell your friend that you are pregnant, she will also tell her friends saying that one is pregnant. It becomes difficult for someone to learn properly because they will be saying, when I go to school my friends will be pointing at me or when we just go for break time, they will be like she is pregnant so it becomes difficult even to concentrate at school. (Female FGD, 18-24 years, Chipata)

While Zambia introduced a re-entry policy in 1997 that requires all schools to grant girl learners maternity leave and then readmit them so they can complete their studies, several barriers related to the altered life situation of the pregnant girl's or motherhood status impede their continuation or reintegration into school despite the enabling policy:

Before the re-entry policy it would be very bad because that would be almost the end of your future… but after the re-entry policy they have allowed that you can still go back to school, but it will still take a toll on you. You have become a mother - a mother at a very young age. First of all, the body changes. It affects you emotionally, mentally, you have to start dealing not only with yourself. You are a child, then you have to deal with

another child. When you go out to play, since you are still a child, they will call you: "your baby is crying". Your school also becomes affected if you are not strong enough because you will lose focus. You have so many things to think about. Maybe the baby was crying the whole night when you were supposed to be studying, therefore it becomes very hard for you to make it [at school] as a mother. (Female FGD, 18-24 years, Mongu)

Further, being out of school while tending to a newborn meant that adolescent girls struggled to academically catch up with their peers:

It's very hard, I have a friend she got pregnant when she was in grade 10, the time that she got pregnant the parents were very upset with her. They told her that they would never take her back to school and she stayed in society for a long time. They waited until the child was 6 years. That's when they took her back to school. Since she overstayed in the community, she became dull because her mind focused mostly on other things than school but before she got pregnant she used to perform very well. So I think that decision is very bad. (Female FGD, 18-24 years, Mongu)

For those who kept their pregnancies, returning to school was often not feasible. The same financial constraints that were an important driver of adolescent pregnancy in the first place also impacted on the ability of families to afford to pay for their child to return to school (i.e. tuition fees, transport, childcare).

If you go back to school then your parents will suffer taking care of you and your baby. Your parents will have difficulties to feed the child and also to look for money to pay for your school. (Female FGD, 18-24 years, Petauke)

Most participants described very bleak future prospects and life options for unmarried adolescent girls who experienced early pregnancies, with the below participant referring to "no more life" at all, with only marriage as a solution:

In my community, they view teen pregnancy as something that has just destroyed the family, and not just that, but more like a burden to the family and to the girl who is pregnant. It has really big negative thoughts surrounding it because our community has accepted that once someone is pregnant there is nothing good that is going to happen to that person. No more life that's all. If they had wanted to be successful in life, they are not going to make it. Most of our community [members] do not even know about the re-entry policy. What they know is once you are pregnant then no more school. What is next for you is marriage, that's all. That's how the community where I come from sees teenage pregnancy. (Male FGD, 18-24 years, Lusaka)

The socioeconomic divide and the veneer of respectability

Throughout the data, there were clear dichotomies between the rural–urban, rich-poor, and married-unmarried divides in terms of acceptability of adolescent pregnancies, experience of stigma and exposure to unsafe abortions. Concern over the age of the pregnant girl was often subordinate to economic and marital status determinants. For example, adolescent pregnancy occurring outside of marriage was commonly associated with loose morality and sexual promiscuity, and highly frowned upon.

I come from different communities, so firstly in the rural community that I come from being pregnant as a teenager is viewed as normal because at your age your friends are getting married. They are having kids. It's something normal once they reach puberty. But in my urban community, it's seen as a shame. You are stigmatised for getting pregnant. Even if it wasn't intentional, because as kids most of them wouldn't want to be pregnant anyway, they are just children. [..] It is viewed as an abomination, a shame to your family and to yourself. All that can lead you to being depressed or your family even asking you to leave the house. (Female FGD, 18-24 years, Lusaka)

As mentioned earlier, a major cause of concern around adolescent pregnancy was the household's ability to financially support another person in the household. Throughout the data and as the below participant, shares, it was clear that the ability of the adolescent girl to financially support a baby, whether it be through her family, herself or her partner, was a key determinant in the acceptability of the teenage pregnancy:

If you come from a well-to-do family, they will accept [it] because they believe you will take care of the female and the child. …if you don't do well in society or are not financially strong, financially dependent, it is unacceptable! (Male FGD, 18-24 years, Lusaka)

For instance, participants shared that pregnancy was more acceptable if the father of the child stepped up and took (financial) responsibility for the child or if a girl was financially independent.

Those who are independent, financially stable and can manage to take care of the children, society finds it easy to accept if such a person gets pregnant

because they know that they will not be troubling anyone. As long as someone is independent. (Male FGD, 18-24 years, Kaoma).

In my community pregnancy is viewed as unacceptable if you don't know who the baby daddy is and if the baby daddy refuses to take up responsibility, or for example you are a teenager, you are not married. It is kind of tricky on the not-married-part: when you got pregnant and you are older and not married or maybe let's say you are a teenager 18, 19 [years old] and you have gotten pregnant and the baby daddy takes responsibility, it moves from being unacceptable to acceptable because someone is bringing diapers. (Female FGD, 18-24 years, Lusaka).

These views were echoed by participants who were also parents:

I can say the only pregnancy which is acceptable is when the child is married because if she is married then me, as a parent, I will not suffer. (Female FGD, 18-24 years, Chipata).

In one FGD in a rural site, it was suggested that adolescent pregnancy was better accepted in wealthier families compared to poorer households:

Nowadays families differ, sometimes you find that someone will impregnate a girl who comes from a well-to-do family and they will accept that pregnancy. Sometimes, even if you are old enough, and you get pregnant from a poor family, your family will not give you attention or like you. They will look at you as someone who is foolish. (Female FGD, 18-24 years, Petauke).

Participant accounts highlighted the inequalities between rich versus poor families in terms of exposure to community censure and stigma around abortion. Being rich, according to participants, meant that girls were sheltered from community censure:

Rich people get away with a lot of things because they have money. Money is power so when you abort they will say "they know how to take care of themselves". As long as you have money you can do anything, it very easy for you to get away with it unlike when you are poor because you have no one to defend you like that. First of all, you don't have money and you do such things? It's like doing wrong things on top of wrong things. (Female FGD, 18-24 years, Mongu).

High levels of stigma were directed towards adolescent girls who were known to have undergone an abortion. As for unintended pregnancy, participants reported that girls who opt to terminate their pregnancy experience similar stigma and exclusion from their community, namely shame and blame:

I think the person who is mostly blamed, laughed at, stigmatized is the young person and they will even say "she aborted because she wanted to play or continue having sexual activities" but for an adult they always find ways or reasons to why she did that. Actually some may say she didn't abort but it was a miscarriage. (Male FGD, >24 years Kaoma).

The whole community will start laughing at her [and say] that "she is a baby killer, she doesn't want to keep the babies". It doesn't look okay in the community. You are young and you are terminating pregnancies, people are not happy, others will hate you and they wouldn't want to sit close or with you. (Female FGD, >24 years, Petauke).

And while abortion was highly stigmatised within the communities, it is important to note that parents were often instrumental in arranging these for their daughters to avoid the shame and the blaming that they may experience from having a girl who got pregnant:

Some people get help from their parents because some parents do not want to be laughed at by the community members. Therefore the moment they notice that their child is pregnant, they will terminate the pregnancy secretly without people knowing. (Female FGD, >24 years, Mongu).

In most cases, these people are encouraged to abort by either their family members, friends or boyfriend but when the issue becomes known to the public, the same people are nowhere to be seen. They will also turn against the same person. That's how bad it is, you are left with no one to confide in. (Male FGD, 18-24 years, Mongu).

Though church spaces were pointed out as drivers of abortion stigma, the data also suggested that parents with key positions in the church and community were involved in ensuring their daughter underwent an abortion to preserve their status amongst the community.

The parents also contribute to abortion, in that for them, they care more about their reputation than the health and well-being of their children because you find that if the parent is an elder or has a position at the church or maybe is a pastor and if the

daughter has the pregnancy, they will have an abortion as soon as possible so that no one knows in the community. Because people respect them and their family and also many people look up to them. (Male FGD, >24 years, Lusaka).

Beyond parents, partners are also reported to influence adolescent girls' decisions of having abortion as highlighted in one of the quotes above. The data also suggest the gendered biases in decision making around abortions where, as the below account illustrates, terminating the pregnancy was in the interest of the father of the pregnancy:

Sometimes it's a man who decides to do an abortion because he will say that his parents want him to continue with school and he won't be able to provide the things for the child. (Male FGD, >24 years, Lusaka).

Regarding the access to the abortion services, the findings show differences in access to services depending on adolescent girls' financial conditions. Having the financial means meant that confidentiality and quality care could be assured through accessing private abortion care.

There is a difference [between the rich and poor] because for those with money, they can do things in secrecy because money will be used. They will go to private hospitals and only a few will know they actually did that. But for those who are poor in one way or the other people will come to know about the abortion because mostly they use traditional medicines and they tend to have high bleeding such that people will always notice that there is something wrong. The poor are the ones who get mistreated mostly because they easily get exposed. (Male FGD, 18-24 years, Mongu).

Finances also played a large part in the choice of provider for abortion care, with traditional healers being cited as the available option for those who could not afford formal care.

People go to where they can afford. If they go the traditional way they will be told that it is very cheap. It is [kwacha] K50 and then they go to the health facility they will be told its K 1500. For a poor person, they would rather go for the traditional way because it's cheaper but the rich will go to the facility because they want perfect services and they can afford it. The majority go the traditional way. The hospital is for the rich. (Male FGD, 18-24 years, Mongu).

Confidentiality, affordability and service access were key factors underlying preference in obtaining services from informal providers. Institutional factors, such as negative health worker attitudes towards adolescents, poor community knowledge of legal abortion care, and discretionary implementation of abortion policy by health workers undermined poor adolescents' power to seek public sector safe abortion services.

When they go to the hospital, they ask a lot of questions. So to avoid those questions they just go to the old grannies, who will not even ask any questions, but just get the medicine and drink. (Male FGD, 18-24 years, Petauke).

Not all the facility staff are welcoming or would allow everyone to come to the facility and access abortion services. They may either chase them or tell them that they will take them to the police. So many of the youth fail to go there to seek for such service. Only those with connections can have access to abortion services at the facility. (Female FGD, 18-24 years, Kaoma).

These dichotomies also meant that those unable to pay for private services were more "exposed" to community level stigma resulting from the disclosures that occur when girls experience abortion-related complications that need medical attention following unsafe abortion methods or procedures.

For the poor, every person will know that they have aborted because they will be sick for a long time. Maybe because of the things they used to abort, because some of them use plants, some use boom paste [washing powder], soda and so on because they cannot even afford to pay for abortion medicine from the pharmacy or pay the clinic staff or buy things that will make them recover fast. But for the rich it's even difficult to know if they aborted or not because they can buy everything that can help them recover quickly and boost their immune system. (Male FGD, >24 years, Mongu).

These same adolescent girls, at the "bottom of the food chain" were the ones whose lives were at stake through lack of access to safe abortion care.

There is a girl that I used to know who used to sell items at the market, I think she was 16 years old and she was pregnant. The man refused to be responsible for that pregnancy but her parents were willing to take care of that child. I just heard that when the pregnancy was I think 6 or 7 months she attempted an abortion then she died. It wasn't even a long time

ago. Last month. (Male FGD, >24 years, Lusaka).

Discussion

Our findings provide insight into the complex interactions between the factors commonly associated with pregnancy and unsafe abortion amongst adolescents in the Zambian context. The discussions with the community members show that adolescent girls potentially faced a triple stigma: stigma around accessing contraception to prevent pregnancy from occurring, stigma in experiencing an unintended and early pregnancy and/or stigma around terminating an unintended pregnancy.

Low economic status and poverty emerged as a key determinant of unintended pregnancies amongst adolescent girls through the pathway of sexual-economic exchanges amongst adolescent girls with often older men in order to meet their (and their family's) basic needs. Our findings add to the evidence which has linked adolescent pregnancy with transactional sex for economic gain with older male sexual partners in SSA [14, 16, 26]. However, our findings also extend this literature by examining the complex interactions between transactional sex and unintended pregnancy and the specific contexts of Zambian communities. In particular, the role of parents in enabling these relationships emerged strongly in the data. Another study reporting on early pregnancy and schooling in rural Zambia highlighted competing discourses of the problem of adolescent pregnancy and valorisation of girls who stayed in schools versus discourses around fertility being prized and the social and economic security of early marriage, cemented by child bearing [3]. The authors noted that the economic dimension of early childbearing did not only include parents encouraging their girl children to enter sexual relationships with boyfriends '*to get something to eat*' (p9), but also included parents arranging early marriages for their daughters in order to receive bridewealth or dowry [3]. Constrained agency through economic precarity which leads to unintended adolescent pregnancies has been found in other research in the region [10].

Importantly, the same economic constraints were also a key factor in how the pregnancy was received by the girl's family and the community, in the experiences of stigma for the girl child and an important determinant in the (dis)continuation of the girl's schooling. Our data highlighted that a major cause of concern around adolescent pregnancy was the household's ability to financially support another person in the household and that the pregnancy was more acceptable if the father of the child acknowledged paternity and financial responsibility for the child or if a girl, herself, was financially independent. The role of the father of the child and his economic responsibilities in the acceptability of pregnancy is echoed in other research in the region. Studies amongst adolescents in informal settlements in South Africa reported pregnancy as a disruptive and stressful period with fears around disclosure of pregnancy and the subsequent upheaval in family and a partner's social support structures [10, 15, 20]. Importantly, our study and others examining unintended pregnancy amongst both adolescent girls and young women (10–24 years) consistently report how parents and other family members can play a key role in mitigating emotional and financial stress and function as key sources of emotional and material support during the antenatal period [10, 18]. In a recent study on pregnancy and motherhood in South Africa amongst economically disadvantaged adolescents, parental support – and particularly maternal support – was a critical dimension in the ability of the adolescent to cope and particularly so when the male partner refused to take responsibility for the child [10].

Conversely, descriptions of the threat of physical violence by family members in our data are cause for serious concern. A recent analysis of demographic health survey data sets in 5 countries in Africa reported a fivefold association with experience of physical violence amongst pregnant adolescents compared to non-pregnant adolescents [32]. However, importantly, the analysis highlights that physical violence is highly associated with adolescent pregnancy in both directions. Adolescent pregnancy occurred over four times more amongst adolescents who had ever experienced any form of physical violence compared to their peers who had never experienced physical violence (ibid). The serious negative impacts of physical violence during pregnancy on maternal and infant health outcomes has been well established [1, 6, 23]. However, given the economic insecurities underlying adolescent pregnancy in our data, it is important to also highlight the evidence showing interactions between socio-economic impacts, violence and pregnancy amongst adolescents. A longitudinal analysis amongst pregnant adolescents in the USA found that intimate partner violence (IPV) negatively impacts later economic earnings years after the violence occurred [19]. These analyses together with Tettah et al. suggest a complex interaction, and bidirectional relationships between socioeconomic status, IPV and adolescent pregnancy and underline that the harmful consequences of violence and impacts of adolescent pregnancy which extend far into the future of the girl child.

Our findings also highlight the role that parents, family members and the broader community play in the stigmatisation of the reproductive health and rights of adolescent girls, including adolescent girls' experiences of stigma around accessing contraception to prevent pregnancy from occurring, stigma in

experiencing an unintended and early pregnancy and/or stigma around terminating an unintended pregnancy. Our data reveals that parents and other family members, sexual partners and community members are often actively involved in securing abortion services for unwanted adolescent pregnancies. However, participants in our focus group discussions clearly identify how wealth inequities play out in terms of being able to secure safe and, perhaps most important to the girl child, confidential abortion services. Again, the same economic constraints that had a role to play in the unintended index pregnancy shaped the type of service an adolescent girl was able to access. Importantly, lack of discrete and quality abortion services and complications arising from unsafe abortion exposed girls to further stigma. Other studies have also documented that adolescent girls and young women experience difficulties in making series of critical choices regarding abortion including tough decisions about their own lives and bodies, considerations of how their choices will be judged by others, as well as how to navigate the considerable stigma that may come as a result of undergoing an abortion [8, 13, 25].

In addition to facing challenges in accessing contraceptive services, they also lack adequate SRH information to prevent pregnancies. Zambia faces ongoing challenges with implementing comprehensive sexuality education (CSE) with delivery of CSE in schools being suboptimal due to cultural and religious morality values and norms [5, 40]. Keeping girls in school is a key intervention for better SRH outcomes [31, 33]. However, our data also suggests that pregnancy and childbirth pose a significant disruption to a girls' ability to participate at school. Our data suggests that even for girls who returned to school after a temporary absence, the disruption posed by pregnancy and/or the physical demands of breastfeeding and caring for a newborn may make it extremely challenging for them to pick up from where they left off. These findings highlight that while the implementation of the policy to return to school is essential, girls may need additional support on returning to school.

Strengths and limitations

A clear strength of this study is the diversity of the study sample and geographical locations for the study which has not been reflected to the same degree in past studies on this topic in Zambia. However, collecting data during an election period - heightening sensitivities around the topic of abortion - made recruitment and the organisation of group discussions more challenging. This challenge was mitigated through the use of neighbourhood health committees and local NGOs/CBOs to recruit FGD participants, as well as through the use of safe spaces to collect data.

Conclusion

Our findings reveal some of the ways that inequalities play out along the reproductive health continuum for adolescent girls. The fact that age, gender and socioeconomic status intersected with economic insecurities in very particular ways to make some adolescent girls (and not others) more vulnerable to poor health and social outcomes highlights the importance of community level approaches in interventions seeking to prevent early and unintended pregnancies. Understanding adolescent pregnancy as a community issue also creates opportunities for community level responses, including support from faith leaders, for adolescent girls who have experienced an early and unintended pregnancy. Reducing the burden of school-related out of pocket costs for families and strengthening of school-based initiatives to support the reintegration of adolescent mothers into school are also key level community interventions. Adolescent friendly services that offer community outreach may help reduce stigma, and improve access and uptake of reproductive health services.

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Authors' contributions

JZ, TC, RO, KJ and CA contributed towards the design of the study including the data collection tools. JZ, TC, and CA participated in collecting data. JZ, TC, RO, KJ and CA participated in analysing the study data. All the authors contributed towards the the draft manuscript, and approved of the final manuscript.

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Availability of data and materials

The datasets during and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethical clearance to conduct this study was sought from the Human Social Sciences Research Ethics Committee, University of KwaZulu-Natal in South Africa, APHRC Institutional Review Board in Kenya, and the National Health Research Authority, and IRB of Excellence in Research Ethics and Science (ERES) Converge in Zambia. The study was carried in line with the Helsinki Declaration. Informed consent to participate in the study was obtained from participants.

Consent for publication

Not applicable.

Competing interests
The authors declare no competing interests.

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