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Original Research Article

Individual and community-level factors associated with unintended pregnancy among adolescent girls and young women in selected Southern African countries: a multilevel analysis

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ABSTRACT

Background: Unintended pregnancy continues to be a huge public health problem in sub-Saharan Africa (SSA), including in Southern Africa, where adolescent girls and young women (AGYW) face higher risks. Therefore, this study aimed to determine the multilevel factors associated with unintended pregnancy among AGYW in Southern Africa.
Methods: This study analysed a weighted sample of 20,748 AGYW (15–24 years) drawn from the most recent Demographic and Health Surveys (DHSs) in nine Southern African countries. We fitted multilevel logistic regression models to examine multilevel factors associated with unintended pregnancy at $p < 0.05$ statistical significance.
Results: The pooled prevalence of unintended pregnancy among AGYW in Southern Africa was 39.1% (95% CI: 38.8–40.1). Higher odds of unintended pregnancy were observed among AGYW with secondary education (aOR=1.88, 95% CI: 1.65–2.13), those exposed to media (aOR=1.14, 95% CI: 1.06–1.22), contraceptive users (aOR=1.24, 95% CI: 1.16–1.33), and urban residents (aOR=1.19, 95% CI: 1.10–1.30). However, AGYW aged 20–24 years (aOR=0.64, 95% CI: 0.60–0.69), and those with a history of pregnancy loss (aOR=0.78, 95% CI: 0.69–0.89) were associated with lower odds of unintended pregnancy.
Conclusion: This study found several multilevel factors associated with unintended pregnancy among AGYW. Governments and sexual and reproductive health (SRH) programmes in Southern Africa should priorities targeted youth-friendly services, expand access to SRH services, and tailor interventions to national and local contexts to reduce unintended pregnancies among AGYW in the region.

Keywords: Adolescent girls and young women, Southern Africa, Unintended pregnancy, Youth-friendly services.

INTRODUCTION

Unintended pregnancy continues to be a huge public health challenge globally, especially in low and middle-income countries (LMICs).[1] An unintended pregnancy is a conception that is mistimed, unplanned, or unwanted at the time of occurrence.[2] Almost half of all pregnancies globally are unintended, with the SSA region mostly

affected by this burden.[3] In SSA, AGYW aged 15-24 years bear the highest burden of unintended pregnancies compared to older women.[4,5] Unintended pregnancy exposes young women to multiple adverse outcomes, including unsafe abortion, maternal mortality, depression, and school dropout which also affects their quality of life and economic stability.[6-8]

The World Health Organization (WHO) recommends SRH services, including family planning, be targeted to young people to prevent unintended pregnancies and their consequences.[9] Without these interventions, AGYW are at increased risk of interrupted education, economic hardship, and long-term health complications.[10]

However, timely access to contraception, combined with accurate SRH information, can substantially reduce the number of unintended pregnancies.[11] Regional efforts in Southern Africa have been made to increase access to SRH services, including distributing condoms to remote areas, school-based SRH education, and establishing youth-friendly services.[12-14]

Despite these interventions, teenage pregnancy remains high in Southern Africa, with a prevalence of 25%, surpassing the global average of 15%.[15] This high prevalence reflects persistent gaps in access to youth-friendly SRH services. Additionally, cultural norms, socioeconomic inequalities, and limited autonomy in reproductive decision-making further exacerbate the issue, leaving many young girls at risk of early childbearing.[16]

Research studies across SSA have identified various factors that are significantly associated with unintended pregnancy. For instance, being younger (15-19 years), not being married, multiparity, having multiple sexual partners, having no formal educational, living in female headed households, residing in Southern, or Eastern Africa, and having poor knowledge of contraceptive methods, were associated with a higher likelihood of unintended pregnancy.[17-21] However, most research studies in Southern African countries have concentrated on women of reproductive age, leaving the specific vulnerabilities of AGYW insufficiently explored.[6,22-25]

To address this gap, this study estimated the pooled prevalence and examined individual and community-level factors associated unintended pregnancy in nine Southern African countries using the most recent Demographic and Health Survey (DHS) data by applying multilevel modelling techniques, which account for the hierarchical structure of DHS data.

The findings of this study are intended to generate evidence that can inform targeted interventions to improve AGYW's access to SRH services in Southern Africa, thereby supporting progress towards achieving Sustainable Development Goal 3 (SDG3): ensuring universal access to reproductive health care and reducing maternal mortality.

METHODS

Study design and study area

This study employed a cross-sectional design analysing Demographic and Health Surveys (DHSs) data collected between 2013 and 2024 from nine Southern African countries: Angola, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe. The datasets from these countries were combined to estimate the prevalence and determine multilevel factors associated with unintended pregnancy among AGYW aged 15-24 years. The Southern African region faces a number of public health challenges, including high prevalences of HIV and teenage pregnancy.[26]

Data source and study population

Data for this analysis were obtained from DHS conducted in nine countries across Southern Africa. The DHS program provides nationally representative data on demographic, health, and SRH indicators. We used the women's individual recode (IR) files, and included AGYW aged 15-24 years who had given birth within five years preceding the survey. AGYW with missing data on the variables of interest were excluded from the analysis.

After applying the sampling weights, a total of 20,748 AGYW were included in the final analysis (Table 1). All the DHS datasets used in this study are publicly accessible from the DHS Program website (http://dhsprogram.com/data/available-datasets.cfm).

Study variables and measurements

Outcome variable

The outcome variable for this study was unintended pregnancy. Pregnancies were classified as intended (coded as '0') if the respondent reported wanting the pregnancy, and unintended (coded as '1') if the pregnancy was either mistimed (wanted later) or unwanted (not wanted at all).

Individual-level variables

The individual-level variables included age (15-19 years, 20-24 years), educational status (no education, primary, secondary, higher education), marital status (not married, married, cohabiting), employment status (employed, unemployed), media exposure (yes, no), age at first sex (less than 18 years, 18 years and above), contraceptive use (using, not using), history of pregnancy loss (yes, no), and sex of household head (male, female).

Community-level variables

The community-level variables were perceived distance to the health facility (big problem, not a big problem), place of residence (urban, rural), and country (Angola, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe).

Data management and statistical analysis

Data was analysed using STATA version 17.0. Survey weights were applied to account for the complex sampling design, ensuring that the results were representative and provided reliable estimates and standard errors. Due to the hierarchical structure of DHS data, multilevel logistic regression models were fitted using the *"melogit"* STATA command to account for both individual and community-level variation.

Descriptive statistics were performed, with categorical variables summarized as frequencies and percentages, while continuous variables were summarized using means and standard deviations (SD). A bivariate analysis was performed using a chi-square test of independence ($\chi 2$) at 95% confidence intervals (CI). Variables with a p value less than 0.20 in the bivariate analysis were considered eligible for inclusion in the multilevel modelling. Multicollinearity was assessed using the variance inflation factor (VIF). The independent variables showed no collinearity (mean VIF=1.14, maximum VIF=1.34, minimum VIF=1.01).

Four models were constructed sequentially. Model 1 was an empty model without the independent variables. Model 2 included only individual-level variables, while Model 3 included only community-level variables. Model 4 combined both individual and community-level variables.

Fixed effects were reported as adjusted odds ratios (aORs) with 95% confidence intervals (CIs) at p value<0.05 statistical significance, and random effects were evaluated using the Intra Cluster Correlation (ICC). Model fitness was assessed using the Likelihood Ratio (LR) test and the Wald Chi-square test. Model comparison was based on the Akaike Information Criterion (AIC) and the Log-Likelihood Ratio (LLR), with the model showing the lowest AIC and highest LLR considered as the best fit.

Ethical considerations

This study used publicly available data from the DHS program, therefore ethical approval was not required. Access to the dataset was granted by the Data Archivist from the DHS program through the Monitoring and Evaluation to Assess and Use Results (MEASURE DHS) online platform (http://www.measuredhs.com).

Detailed information regarding the ethical considerations and data usage of the DHS program is available at http://goo.gl/ny8T6X.

RESULTS

Background characteristics of the study participants

This study analysed a weighted sample of 20,748 AGYW aged 15-24 years from nine Southern African countries. The mean age was 20.8 years (SD=2.3), with a majority of AGYW aged 20-24 years (72.4%; n=15,015). Most of the AGYW (47.3%; n=9,820) had completed primary education, while 40.3% (n=8,363) completed secondary level education, and a majority of the study participants (48.7%; n=10,097) were married. Approximately 54% (n=11,151) of the study participants were employed. Most of the respondents had their sexual debut before the age of 18 years (90.3%; n=18,735), while approximately 93% (n=19,211) of AGYW reported no history of pregnancy loss. A majority of the AGYW lived in male-headed households (71.3%; n=14,799), and most resided in rural areas (69.4%; n=14,395). The majority of AGYW came from Malawi (24.3%; n=5,051) and the least came from South Africa (2.2%; n=449) (Table 2).

Prevalence of unintended pregnancy among adolescent girls and young women

The pooled prevalence of unintended pregnancy among AGYW in Southern Africa was 39.1% (95% CI: 38.8 - 40.1). The prevalence varied across the nine countries, with AGYW from South Africa experiencing the highest unintended pregnancy (71.9%, 95% CI: 66.0 - 77.1) and AGYW from Madagascar experiencing the lowest (13.0%, 95% CI: 11.7 - 14.3) (Figure 1).

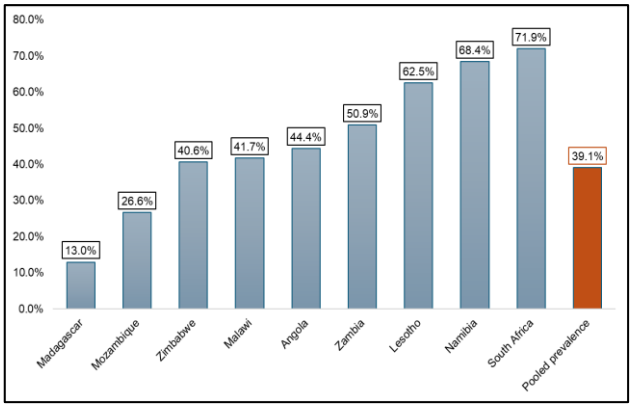

Figure 1: The prevalence of unintended pregnancy among AGYW in the nine Southern African countries.

Random effects analysis and model fitness

The random effects analysis shows that there were statistically significant variations in unintended pregnancy between clusters of the primary sampling units ($\sigma 2$=0.14, 95% CI: 0.11-0.17). The ICC in the null model

indicated that 4.0% of the variability in unintended pregnancy among AGYW was attributable to between-cluster differences. Model 4 was selected as the best-fitted model due to its highest log likelihood (−11,818.18) and the lowest AIC (23,682.36). This model was used to interpret the fixed effects results (Table 3).

Individual and community-level factors associated with unintended pregnancy

In the final model (Model 4), after controlling for both individual and community-level variables, the study found that AGYW aged 20-24 years had 36% (aOR=0.64, 95% CI: 0.60-0.69) lower odds of experiencing unintended pregnancy compared to those aged 15-19 years. Compared with AGYW with no formal education, those with primary, secondary and higher education had 38% (aOR=1.38, 95% CI: 1.22-1.55), 88% (aOR=1.88, 95% CI: 1.65-2.13) and 87% (aOR=1.87, 95% CI: 1.39-2.52) higher odds of experiencing unintended pregnancy, respectively. Additionally, married AGYW had 71% (aOR = 0.29, 95% CI: 0.27-0.32) lower odds of unintended pregnancy compared to their unmarried counterparts. Media exposure among AGYW was associated with 14% (aOR=1.14, 95% CI: 1.06-1.22) higher odds of experiencing unintended pregnancy, compared to not being exposed. Current contraceptive users had 24% (aOR=1.24, 95% CI: 1.16-1.33) higher odds of unintended pregnancy compared to non-users. AGWY with a history of pregnancy loss had 22% (aOR=0.78, 95% CI: 0.69-0.89) lower odds of unintended pregnancy, compared to those without a history of pregnancy loss. AGYW who were urban residents had 19% (aOR=1.19, 95% CI: 1.10-1.30) higher odds of experiencing unintended pregnancy compared to those who were rural residents. The odds of unintended pregnancy were higher among AGYW from Lesotho (aOR=2.41, 95% CI: 1.94-2.98), and South Africa (aOR=1.88, 95% CI: 1.47-2.40), compared to those from Angola (Table 4).

Table 1: Description of the countries, survey years, and the samples used in this study.

Country	Survey year	Unweighted sample (N)	Weighted sample (n)	%
Angola	2023-24	3,474	3,221	15.5
Lesotho	2023-24	712	603	2.9
Madagascar	2021	3,591	3,587	17.3
Malawi	2015-16	4,971	5,051	24.3
Mozambique	2022-23	2,472	2,599	12.5
Namibia	2013	1,217	1,151	5.6
South Africa	2016	443	449	2.2
Zambia	2018	2,642	2,593	12.5
Zimbabwe	2015	1,509	1,494	7.2
Total	-	21,031	20,748	100

Table 2: Background characteristics and distribution of the participants by unintended pregnancy in the nine Southern African countries (Weighted n=20,748).

Variables	Total (weighted %)	Pregnancy intentions (weighted %)		P value
		Unintended (%)	Intended (%)	
Individual-level factors				
Age (in years) (mean=20.8 years, SD=2.3)				< 0.001
15-19	5,733 (27.6)	2,628 (32.4)	3,105 (24.6)	
20-24	15,015 (72.4)	5,480 (67.6)	9,535 (75.4)	
Educational level				< 0.001
No education	2,285 (11.0)	525 (6.5)	1,760 (13.9)	
Primary	9,820 (47.3)	3,409 (42.0)	6,411 (50.7)	
Secondary	8,363 (40.3)	4,026 (49.7)	4,337 (34.3)	
Higher	280 (1.4)	148 (1.8)	132 (1.1)	
Marital status				< 0.001
Not married	6,625 (31.9)	3,897 (48.1)	2,728 (21.6)	
Married	10,097 (48.7)	2,914 (35.9)	7,183 (56.8)	
Cohabiting	4,026 (19.4)	1,297 (16.0)	2,729 (21.6)	
Employment status				< 0.001
Unemployed	9,597 (46.3)	4,233 (52.2)	5,364 (42.5)	
Employed	11,151 (53.7)	3,875 (47.8)	7,276 (57.5)	
Media exposure				< 0.001
No	8,435 (40.7)	2,779 (34.3)	5,656 (44.7)	
Yes	12,313 (59.3)	5,329 (65.7)	6,984 (55.3)	

Continued.

Variables	Total (weighted %)	Pregnancy intentions (weighted %)		P value
		Unintended (%)	Intended (%)	
Age at first sex (in years) (mean = 15.9 years, SD = 2.1)				0.985
Less than 18 years	18,735 (90.3)	7,321 (90.3)	11,414 (90.3)	
18 years and above	2,013 (9.7)	787 (9.7)	1,226 (9.7)	
Contraceptive use				< 0.001
Not using	11,576 (55.8)	4,285 (52.8)	7,291 (57.7)	
Using	9,172 (44.2)	3,823 (47.2)	5,349 (42.3)	
History of pregnancy loss				< 0.001
No	19,211 (92.6)	7,644 (94.3)	11,567 (91.5)	
Yes	1,537 (7.4)	464 (5.7)	1,073 (8.5)	
Sex of household head				< 0.001
Male	14,799 (71.3)	5,165 (63.7)	9,634 (76.2)	
Female	5,949 (28.7)	2,943 (36.3)	3,006 (23.8)	
Community-level factors				
Perceived distance to the health facility				< 0.001
Big problem		3,316 (40.9)	5,899 (46.7)	
Not a big problem	11,533 (55.6)	4,792 (59.1)	6,741 (53.3)	
Place of residence				< 0.001
Rural	14,395 (69.4)	4,976 (61.4)	9,419 (74.5)	
Urban	6,353 (30.6)	3,132 (38.6)	3,221 (25.5)	
Country				< 0.001
Angola	3,221 (15.5)	1,430 (17.6)	1,791 (14.1)	
Lesotho	603 (2.9)	377 (4.7)	226 (1.8)	
Madagascar	3,587 (17.3)	465 (5.7)	3,122 (24.7)	
Malawi	5,051 (24.3)	2,108 (26.0)	2,943 (23.3)	
Mozambique	2,599 (12.5)	692 (8.5)	1,907 (15.1)	
Namibia	1,151 (5.6)	787 (9.7)	364 (2.9)	
South Africa	449 (2.2)	323 (4.0)	126 (1.0)	
Zambia	2,593 (12.5)	1,319 (16.3)	1,274 (10.1)	
Zimbabwe	1,494 (7.2)	607 (7.5)	887 (7.0)	

Table 3: Random effects results and model fitness.

Random effects results				
PSU variance (95%CI)	0.14 (0.11-0.17)	0.15 (0.12-0.19)	0.10 (0.08-0.14)	0.11 (0.09-0.15)
ICC (%)	4.00%	4.30%	3.00%	3.30%
LR Test	$\chi2$=188.62, p<0.001	$\chi2$=176.75, p<0.001	$\chi2$=100.49, p<0.001	$\chi2$=108.21, p<0.001
Wald Chi-square	Reference	2064.64***	1946.90***	2967.03***
Model fitness				
Log-likelihood	−13,788.19	−12,611.15	−12,587.56	−11,818.18
AIC	27,580.37	25,248.30	25,199.12	23,682.36
BIC	27,596.28	25,351.70	25,294.57	23,865.29
N	20,748	20,748	20,748	20,748

Significant at: ***p<0.001

Table 4: Individual and community-level factors associated with unintended pregnancy among AGYW in nine Southern African countries (N =20,748).

Variables	Model 1 (Null)	Model 2 aOR(95%CI)	Model 3 aOR(95%CI)	Model 4 aOR(95%CI)
Individual-level factors				
Age (ref: 15-19 years)				
20-24		0.73 (0.68-0.78)***		0.64 (0.60-0.69)***
Educational level (ref: No education)				
Primary		1.73 (1.54-1.94)***		1.38 (1.22-1.55)* **
Secondary		2.40 (2.13-2.71)***		1.88 (1.65-2.13)***

Continued.

Variables	Model 1 (Null)	Model 2 aOR(95%CI)	Model 3 aOR(95%CI)	Model 4 aOR(95%CI)
Higher		2.97 (2.25-3.94)***		1.87 (1.39-2.52)***
Marital status (ref: Not married)				
Married		0.30 (0.28-0.32)***		0.29 (0.27-0.32)***
Cohabiting		0.39 (0.35-0.43)***		0.43 (0.39-0.48)***
Employment status (ref: Unemployed)				
Employed		0.74 (0.70-0.79)***		0.94 (0.88-1.01)
Media exposure (ref: No exposure)				
Yes		1.23 (1.15-1.32)***		1.14 (1.06-1.22)**
Contraceptive use (ref: Not using)				
Using		1.33 (1.24-1.42)***		1.24 (1.16-1.33)***
History of pregnancy loss (ref: No history of pregnancy loss)				
Yes		0.73 (0.64-0.82)***		0.78 (0.69-0.89)***
Sex of household head (ref: Male)				
Female		1.13 (1.05-1.22)**		1.01 (0.94-1.09)
Community-level factors				
Perceived distance to the health facility (ref: Big problem)				
Not a big problem			1.18 (1.11-1.26)***	1.12 (1.04-1.20)**
Residence (ref: Rural)				
Urban			1.46 (1.36-1.58)***	1.19 (1.10-1.30)***
Country (ref: Angola)				
Lesotho			2.41 (1.99-2.91)***	2.41 (1.94-2.98)***
Madagascar			0.21 (0.18-0.24)***	0.22 (0.19-0.25)***
Malawi			1.09 (0.98-1.20)	1.44 (1.27-1.64)***
Mozambique			0.50 (0.45-0.57)***	0.58 (0.51-0.66)***
Namibia			2.86 (2.46-3.32)***	1.66 (1.41-1.96)***
South Africa			3.28 (2.62-4.11)***	1.88 (1.47-2.40)***
Zambia			1.39 (1.24-1.55)***	1.51 (1.32-1.73)***
Zimbabwe			0.95 (0.83-1.09)	1.02 (0.87-1.19)

Significant at: *p<0.05, **p<0.01, ***p<0.001

DISCUSSION

This study aimed to estimate the pooled prevalence of unintended pregnancy and its associated factors among AGYW in nine Southern African countries. The overall prevalence was 39.1% (95% CI: 38.8-40.1) in Southern Africa. The prevalence in this study was higher than that reported in previous studies conducted in SSA, LMICs, and Ethiopia.[1,18,27] The differences in the pooled prevalence may reflect different cultural norms around family planning, differences in health care systems, and unequal access to reproductive health services. Countries with well-established family planning programs are more likely to prevent unintended pregnancies through timely counselling and method provision.

This study found that AGYW aged 20-24 years were associated with lower odds of unintended pregnancy compared to those aged 15-19 years, a pattern similar to findings from a study conducted in Ghana.[28] Age influences reproductive knowledge, autonomy, relationship dynamics, and healthcare-seeking behaviour, all of which affect pregnancy planning and contraceptive use. Furthermore, adolescence involves major psychosocial, physiological, and cognitive changes that can increase sexual curiosity and experimentation, thereby increasing the likelihood of risky sexual behaviours and adverse SRH outcomes, including unintended pregnancy.[29] These findings indicate that younger adolescents remain at higher risk of unintended pregnancy and should be prioritized in pregnancy prevention efforts.

Similar to the findings of a study conducted in SSA high-fertility countries, higher educational attainment was associated with higher odds of unintended pregnancy.[17] This glaring finding may indicate gaps in SRH service quality and delivery for educated young women, such as method dissatisfaction, inconsistent use, and contraceptive failure despite hiving proper SRH information typically assumed for education. Additionally, educated AGYW may be more likely to classify pregnancies as unintended because of their ambitions, such as continuing education and building their careers. The study further revealed that married and cohabiting AGYW had lower odds of unintended pregnancy compared to unmarried AGYW, a finding that is consistent with studies conducted in Ethiopia, and Asia, which also found that married and cohabiting women were less likely to report unintended pregnancies.[18,30] The possible explanation might be that married and cohabiting

women may have clear fertility intentions and greater social acceptance of pregnancy within formal unions, leading to women in unions reporting fewer pregnancies as unintended.[31]

Exposure to media was associated with higher odds of unintended pregnancy. Evidence from studies conducted in SSA highlights that media exposure often correlates with risky sexual behaviours, as young people exposed to media may encounter pornographic content or engage in sexting, which can negatively shape their sexual behaviour and increase the risk of unintended pregnancies.[32] Furthermore, media content itself may be mixed as some messages promote SRH, while others normalise risky behaviour or give incomplete information about effective contraceptive use.[33] These findings highlight the importance of using media strategically to provide accurate and practical SRH.

In this study, current contraceptive use was associated with higher odds of unintended pregnancy among AGYW. Contrary to our finding, a study in Uganda found that women who were using contraceptives were less likely to experience an unintended pregnancy.[20] The contrasting findings may be due to differences in study settings, barriers to healthcare access, the youth friendliness of services, and local social and cultural norms surrounding contraceptive use. To reduce unintended pregnancies among contraceptive users, health providers should ensure method-specific counselling, offer follow-ups for side effects and method switching.

Consistent with findings from an Ethiopian study, the study found that a history of pregnancy loss was associated with lower odds of unintended pregnancy.[34] Experiencing a miscarriage or stillbirth often increases the desire for pregnancy and accelerates attempts to conceive, making subsequent pregnancies more likely to be intended.[35] Clinically, these women may receive targeted counselling and closer follow-up, which supports timely conception and discontinuation of contraceptive use.

This study further revealed that urban residence was associated with higher odds of unintended pregnancy, similar to findings from a study in SSA.[27] The possible reasons might be that AGYW in urban areas are exposed to distinct factors and urban environments that increase pregnancy risk, such as access to technology and dating apps, increased sexual activity, casual dating, nightlife, and substance use.[36,37] Furthermore, access to SRH services is sometimes uneven and not always youth-friendly, therefore, urban AGYW may rely on short-acting or informal contraceptive methods and face supply interruptions.[38,39] Strengthening youth-friendly services in urban areas, especially in high-risk areas (i.e., universities and colleges, transport hubs, and nightlife areas) should be prioritized to reduce unintended pregnancies among AGYW.

The residence country of the AGYW was also significantly associated with unintended pregnancy, with AGYW residing in Lesotho, Malawi, Namibia, South Africa, and Zambia having higher odds of unintended pregnancy compared to those living in Angola, whereas those living in Madagascar and Mozambique had lower odds, similar to a previous study conducted in SSA, where there were geographical disparities in unintended pregnancy among AGYW.[21] These geographical disparities can be attributed to differences in healthcare systems, national adolescent SRH policies and programmes, and differences in survey years for the different SSA countries.

Strengths and limitations

The strengths of this study are the use of nationally representative datasets, a large sample size, and the application of multilevel modelling analysis techniques, which accounted for both individual and community-level variables. However, limitations in this study included the use of a cross-sectional design, which makes it impossible to establish causality and temporality between the outcome variable and independent variables. There is also the possibility of response and social desirability bias due to self-reported data on pregnancy intention.

CONCLUSION

This study found that the pooled prevalence of unintended pregnancy among AGYW in Southern Africa was 39.1% (95% CI: 38.8-40.1). The findings revealed that AGYW with primary, secondary, and higher education, those exposed to media, current contraceptive users, those who perceived distance to a health facility as not a big problem, and those residing in urban areas had higher odds of unintended pregnancy. However, married and cohabiting AGYW, those with a history of pregnancy loss, and AGYW aged 20-24 years were associated with lower odds of unintended pregnancy. Therefore, governments and SRH programmes from Southern African countries need to develop targeted interventions to address unintended pregnancy among AGYW. Improving SRH education, expanding healthcare access in high-risk areas, and expanding access to long-acting reversible contraception alongside emergency options are critical steps towards reducing unintended pregnancy.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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