PARENTS' PERCEPTIONS TOWARDS ADOLESCENTS' USE OF CONTRACEPTIVES IN CHAWAMA TOWNSHIP

BY

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DECLARATION

I, **Pamela Namakando**, hereby declare that this Dissertation herein presented is entirely the result of my own personal effort and has not been previously submitted either wholly or in part for any diploma, degree or any other qualifications at this or any other university. It has been written according to the guidelines for Master of Science in Midwifery of the University of Zambia.

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I, PROF.CATHERINE NGOMA, having supervised and read through this Dissertation, I am satisfied that this is the original work of the author under whose name it is presented. I also confirm that the work has been completed satisfactorily and approve this Dissertation for final submission

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CERTIFICATE OF APPROVAL

The University of Zambia approves this Dissertation by PAMAELA C NAMAKANDO on "PERCEPTIONS OF PARENTS TOWARDS THE USE OF CONTRACEPTIVES BY ADOLESCENTS IN CHAWAMA TOWNSHIP – A COMMUNITY BASED SURVEY" in partial fulfilment for the requirements for the award of the Degree of Master of Science in Midwifery.

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ABSTRACT

Background: Adolescent girls have a high prevalence of unintended pregnancies. Adolescent reproductive health is an area of major public health challenge, in which unintended pregnancies and maternal mortality due to pregnancy are the top causes of death among adolescent girls globally. Despite the availability of contraceptives, their use is low among African adolescents, a situation partly attributable to parental disapproval and societal stigma. The study aimed to assess the perception of parents of adolescents in Chawama township of Lusaka.

Methods: A descriptive cross-sectional design was employed and a sample size of 258 parents was drawn by simple random sampling in Chawama township of Lusaka District, Zambia. Data were collected using a researcher-administered questionnaire that was developed by the researcher. Both descriptive and inferential analyses were computed using Statistical Package for Social Statistics version 27.

Results: The results revealed that a slight majority (51.5%) held negative perceptions of adolescent contraceptive use; a significant proportion (43.5%) of respondents possess an average level of knowledge about contraceptives; a significant majority (67.4%) of respondents hold negative attitudes towards contraceptives; and a slight majority (56.9%) of respondents reported having supportive and open communication with adolescents regarding sexual and reproductive health. Independent predictors of positive perception toward adolescent contraceptive use included average knowledge level [AOR: 4.8; 95% CI: 1.5–10.2; $p = 0.006$], adequate knowledge level [AOR: 3.9; 95% CI: 1.8–12.4; $p = 0.001$], positive attitudes [AOR: 3.3; 95% CI: 1.7–6.4; $p < 0.001$], and supportive sexual and reproductive health communications [AOR: 4.4; 95% CI: 2.3–8.4; $p < 0.001$].

Conclusion. This study reveals that 51.5% of parents in Chawama Township, Lusaka, Zambia, hold negative perceptions of adolescents' contraceptive use. Factors associated with positive perceptions include adequate knowledge, positive attitudes, and supportive communication regarding contraceptives. Emphasizing education and effective communication is vital for shaping favourable views. The findings suggest that interventions should enhance parental knowledge and attitudes to improve adolescent access to contraceptives, fostering a more supportive environment for sexual and reproductive health.

Keywords: *Adolescent contraceptive use, parental perceptions, sexual and reproductive health, social-cultural norms, Lusaka*

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AOR	Adjusted Odds Ratios
COR	Crude Odds Ratios
CPR	Contraceptive Prevalence Rate
FP	Family Planning
HIV	Human Immunodeficiency Virus
LARCs	Long-Acting Reversible Contraceptives
SEM	Social-Ecological Model
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage
UNESCO	United Nations Educational Scientific and Cultural Organization
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.0 Introduction

Use of contraceptives among adolescents draw varied reactions and emotions based on individual and societal beliefs. Often, adolescents known to have sought or those using contraceptive services experience stigma and social exclusion within their communities and more rebuke from parents and the elderly (Silumbwe et al., 2018). Understanding parental perception of use of contraceptives by adolescents is critical in informing the design and delivery of interventions that reduce the gaps in access to contraceptives by adolescents. This chapter introduced the research topic on parents' perceptions towards adolescents' use of contraceptives in Chawama Township, Lusaka, Zambia. It provided a comprehensive background of the issue, identified the problem, justifies the study's significance, outlined the conceptual framework, and presented the research questions, objectives, and study variables.

1.1 Background Information

Adolescence is the transitional phase from childhood to adulthood, marked by biological and social role changes (Sawyer et al., 2018). This critical formative period influences lifelong health outcomes and national sustainable development (World Health Organization [WHO], 2018). Risky behaviours, such as unprotected sex, lead to unintended pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS). Family planning (FP) mitigates these risks by preventing unintended pregnancies, reducing unsafe abortions, and delaying childbirth for adolescents at heightened health risk. Contraceptives like condoms also protect against STIs and HIV (WHO, 2018).

Globally, approximately 21 million girls aged 15–19 and 2 million under 15 become pregnant annually in developing regions, with nearly half of these pregnancies unintended (WHO, 2018; Darroch et al., 2016). Complications from pregnancy and childbirth are the second leading cause of death among adolescent girls in low-income countries, contributing to 70,000 annual maternal deaths (United Nations Educational Scientific and Cultural Organization [UNESCO], 2017). Early pregnancies disrupt education, limit econoamic opportunities, and perpetuate poverty

cycles, while infants born to adolescent mothers face higher health risks (Wado et al., 2019; UNESCO, 2017).

In sub-Saharan Africa, adolescent pregnancy rates are highest globally, with 1 in 4 girls in West Africa and 1 in 18 before age 15 becoming pregnant (WHO, 2018). The region's high total fertility rate (4.6 children per woman) and early marriages exacerbate these challenges (Zambia Statistics Agency et al., 2019). Despite universal knowledge of modern contraceptives, uptake remains low, with a 21% contraceptive prevalence rate (CPR) among adolescents in low-income countries (Hounton et al., 2015; Chola et al., 2020). Barriers include lack of awareness, misconceptions, confidentiality concerns, and parental disapproval rooted in cultural or religious beliefs (Kumar et al., 2018; Mutea et al., 2022).

Parental attitudes significantly influence adolescent contraceptive use. Open parent-adolescent communication about sexual and reproductive health (SRH) reduces misconceptions and promotes safer behaviours (Moyer-Guse et al., 2020; Widman et al., 2016). Conversely, conservative parental views and fears of promiscuity often deter adolescents from accessing services (Mutea et al., 2022). In Zambia, despite youth-friendly health services, low uptake persists due to parental scepticism and limited SRH dialogue (O'Rourke-Suchoff et al., 2018). Early sexual debut and unintended pregnancies remain prevalent, with school dropout rates rising due to adolescent childbearing (Zambia Statistics Agency et al., 2019).

Modern contraceptives are critical for reducing unintended pregnancies, though inconsistent use and method failures mean some pregnancies still occur (Biddlecom et al., 2018). Long-acting reversible contraceptives (LARCs) are recommended for their cost-effectiveness and reliability (Biddlecom et al., 2018). However, gaps persist in understanding how parental perceptions shape adolescent contraceptive access in Zambia, particularly in urban townships like Chawama. Addressing this knowledge deficit is vital to improving maternal health outcomes and breaking cycles of poverty. Thus, this study examined parental perceptions toward adolescent contraceptive use in Chawama Township, Lusaka, to identify barriers and inform context-specific interventions that align with global efforts to reduce maternal mortality and improve adolescent health outcomes.

1.2 Statement of the Problem

Despite efforts to promote adolescent reproductive health in Zambia, teenage pregnancy rates remain alarmingly high, with 27% of girls aged 15–19 having begun childbearing (Kasimbo, 2022). Parental opposition to contraceptive use is a significant barrier, exacerbated by cultural taboos surrounding adolescent sexuality and limited awareness of modern contraceptive methods (Chola et al., 2020). While Zambia's National Adolescent Health Policy advocates for inclusive FP education, implementation gaps persist, particularly in urban townships like Chawama, where socioeconomic disparities limit access to services. The numbers of adolescents accessing contraceptives is very low at Chawama First Level Hospital as seen in table 1.1.

Table 1. 1: Adolescent Reproductive Health Statistics for Chawama Level 1 Hospital – Lusaka (2020)

S/N	Indicator	10-14	15-19	Females	Total
1	Number of pregnant adolescents who attended 1st ANC visits	04	227	736	736
2	Number of adolescent with positive pregnancy test.	00	47	180	180
3	Number of adolescents accessing FP services	00	207	1,417	1,417
4	Number of condoms distributed	00	-	-	4,256
5	Number of adolescent tested HIV+	3	11	53	63
6	Number of adolescent tested positive for STIs	0	04	6	6

Source: Lusaka District Health Office, 2021

Data from Chawama Level 1 Hospital (2020) reveals that 736 adolescents attended their first antenatal care (ANC) visit, with 180 testing positive for pregnancy. Notably, only 1,417 adolescents accessed FP services, highlighting a stark disparity between contraceptive need and utilization (Table 1.1). This low uptake persists despite the availability of safe and effective contraceptive methods, suggesting systemic barriers such as parental consent requirements, which studies identify as a critical determinant of adolescent FP access (Chola et al., 2020).

Parental disapproval based on misconceptions about contraceptives hinders adolescent access to FP services, heightening risks of unintended pregnancies, unsafe abortions, and STIs, including HIV (Molefe and Nyangu, 2025). In 2020, 63

adolescents tested HIV-positive, with 10 diagnosed with STIs at Chawama Hospital (Table 1.1), highlighting the need for targeted interventions. Current strategies, such as youth-friendly clinics and condom distribution (4,256 in 2020), have not effectively tackled parental scepticism or enhanced parent-adolescent communication about SRH (Brown, 2000; Belsky et al., 2020). Failure to address these barriers perpetuates early pregnancies, maternal mortality, and educational interruptions. This study aimed to explore parental perceptions in Chawama Township and their impact on adolescent FP access, providing evidence to improve health policies and outcomes.

1.3 Study Justification

This study has addressed critical gaps in adolescent SRH interventions in Zambia. First, while existing research had predominantly centred on adolescents' perspectives and healthcare provider practices, parental perceptions—a pivotal yet understudied determinant of contraceptive access—remained poorly understood, particularly in high-density, low-resource settings like Chawama Township. Understanding parental attitudes was essential, as families in Zambia often act as gatekeepers to adolescents' SRH choices, with cultural and religious norms heavily influencing decisions (Chitundu et al., 2018). Second, the findings could advance progress toward Universal Health Coverage (UHC) by advocating for interventions that bridge systemic and socio-cultural barriers. For instance, aligning parental education programs with Zambia's national SRH strategies could enhance community trust in healthcare systems, thereby improving equitable access to contraceptives (Chola et al., 2020).

Third, at the local level, the study's insights could empower Chawama policymakers and health stakeholders to design context-specific initiatives, such as parent-adolescent dialogue platforms or culturally tailored SRH campaigns, to reduce stigma and unintended pregnancies. Failure to address parental resistance risks perpetuating Zambia's high adolescent fertility rate, which stands at 119 births per 1,000 girls aged 15–19, nearly double the global average (Chola et al., 2020). By integrating parental perspectives into SRH frameworks, this study has contributed directly to Sustainable Development Goals 3 (health and well-being) and 5 (gender equality), fostering

environments where adolescents can exercise their SRH rights without compromising familial or cultural values.

1.4 Research Question

What are the perceptions of parents towards the use of contraceptives by the adolescents in Chawama Township?

1.5 Objectives of the Study

1.5.1 General Objective

To assess the perception of parents towards the use of contraceptives by adolescents in Chawama township of Lusaka.

1.5.2 Specific Objectives

1. To determine the level of parental perception toward adolescents' use of contraceptives in Chawama township of Lusaka.
2. To examine the influence of parental knowledge of contraceptives on their perception towards adolescents' use of contraceptives in Chawama township of Lusaka.
3. To determine the influence of parental attitudes on their perception towards adolescents' use of contraceptives in Chawama township of Lusaka.
4. To explore the influence of communication patterns between parents and adolescents on their perception level.

1.6 Conceptual Framework

1.6.1 Description of the adapted Model

This study's conceptual framework was adapted from the social-ecological model (SEM), rooted in early human psychology and child development research, particularly Lewin's (1935) assertion that behaviour (B) is a function of person (P) and environment (E): B = f (P, E). Bronfenbrenner, a Lewin disciple, expanded this model to highlight the complex interactions in human development, emphasizing the importance of the entire ecological system and later incorporating biological and genetic factors (McLeroy et al., 1988).

The social ecological model broadly conceptualizes health, encompassing physical, mental, and social well-being, as outlined in the 1947 WHO Constitution. It emphasizes the interplay between individuals, communities, and their environments (Sallis et al., 2018; Wallerstein et al., 2003). This model has been adapted to explore parental perceptions of adolescent contraceptive use, recognizing numerous interacting layers of environmental, social, and communal factors influencing behaviour. Central to the model is the individual, whose behaviour is shaped by personal beliefs and knowledge. The framework's layers include interpersonal factors (social networks and support), community factors (relationships among organizations and resources), organizational influences (systems and norms), and policy levels (local to national guidelines). Its main strength lies in integrating behavioural and environmental factors to assess parental perceptions of contraceptive use (Stokols, 1996).

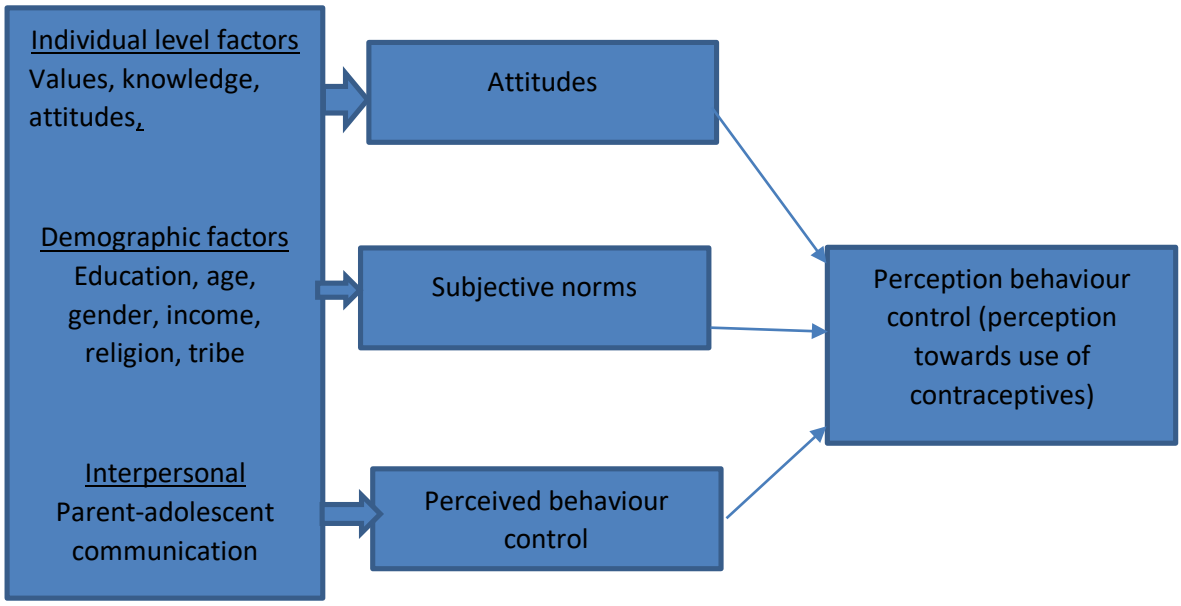

Figure 1. 1: The adapted Social Ecological Model. (Source: adapted from the Centers for Disease Control and Prevention (CDC): *https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity/framing-the-issue.html)*

1.6.2 Application of the adapted Model to the Study

The adapted SEM was applied to the study by examining how intrapersonal factors (e.g., parental knowledge and attitudes), and interpersonal factors (e.g., parent-adolescent communication), influence parental perceptions towards adolescents' use of contraceptives. Parents' personal beliefs about adolescent sexuality, contraception,

and the perceived risks and benefits of contraceptive use. For instance, some parents may hold strong religious or moral views that oppose premarital sex and contraceptive use, which can negatively impact their perceptions.

Parental level of knowledge about sexual and reproductive health, including the types of contraceptives available, their effectiveness, and potential side effects, can lead to misconceptions and fear, influencing their perception towards adolescents' use of contraceptives.

The quality and frequency of communication between parents and adolescents about sexual and reproductive health. Open, honest, and supportive communication can positively influence parental perceptions and encourage adolescents to make informed decisions about contraceptive use. Conversely, lack of communication or negative interactions can reinforce stigma and hinder access to contraceptives.

1.7 Study Variables

1.7.1 Dependent variable

Perception of use of contraceptives

1.7.2 Independent variables

1. Knowledge on contraceptives and sexuality
2. Attitudes toward contraceptives
3. SRH Communication

Table 1. 2: Description of study variables

Variable	Conceptual definitions	Operational definitions	Indicators	Cut off points	Question number
Dependent variable					
Perception of use of contraceptives among adolescents by parents	Perception is a subjective, active, and creative process through which we assign meaning to sensory information to understand ourselves and others (Janet, 2017).	In this study perception was used to understand parents' opinion on unmarried children using contraceptives for pregnancy prevention and whether they could get a contraceptive and give their children.	Positive	Scores of 50% and above on perception questions	16 – 18
			Negative	Scores of 49% and below on perception questions	
Independent variables					
Knowledge on contraceptives & sexuality	Refer to a skill in, understanding of, or information about something, which a person gets by experience or study (Janet, 2017).	In this study, knowledge referred to awareness and knowledge of how to use contraceptives, source, knowledge of sexuality issues and knowledge of risks of unprotected sex.	Adequate	Scores of 70% and above on knowledge questions	9 – 13
			Average	Scores of 50 – 69% on knowledge questions	
			Inadequate	Scores of 49% and below on knowledge questions	
Attitude & beliefs toward contraceptives	Refer to personal belief patterns which are acquired through the	In this study, referred to parental attitudes & beliefs on how they feel about	Positive	Scores of 50% and above on attitude questions	14 (A to G)

	socialization process (Blankenship and Stewart, 2022).	adolescents' use of contraceptives.	Negative	Scores of 49% and below on attitude questions	
SRH communication	This refers to communication often involving parents and adolescents, but can also include other family members, caregivers, and health professionals on SRH (Maina et al., 2020)	Referred to the quality and frequency of communication between parents and adolescents about sexual and reproductive health.	Supportive	Scores of 50% and above on SRH communication questions	15 (A to E)
			Poor	Scores of 49% and below on SRH communication questions	

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This literature review synthesized evidence on parental perceptions toward adolescents' contraceptive use in Chawama Township, Lusaka, Zambia, contextualizing findings within global, regional, and local frameworks. The review drew on peer-reviewed articles sourced from databases such as PubMed, Google Scholar, ScienceDirect, and Scopus, using keywords including "parental perceptions," "adolescent contraceptive use," "Zambia," "socio-cultural barriers," and "sexual and reproductive health." Studies were prioritized based on their relevance to parental attitudes, knowledge gaps, and socio-cultural dynamics in low-resource settings. The review addressed the intersection of parental influence, cultural norms, and SRH outcomes, highlighting the unique challenges faced in Chawama, a high-density urban settlement with documented disparities in adolescent SRH access (Munakampe et al., 2021b).

2.1 Overview of Parental Perception and Views Toward Adolescents' Use of Contraceptives

Parental perceptions of adolescent contraceptive use are deeply rooted in cultural, religious, and societal norms (Munakampe et al., 2021b). Globally, parental perceptions of adolescent contraceptive use are shaped by cultural, religious, and socio-economic factors. In conservative Indian societies, Shukla et al. (2022) highlighted parental resistance was rooted in fears that contraceptive access encourages premarital sexual activity, leading to restrictive attitudes and limited SRH education. In the Middle East, research from Saudi Arabia reveals that 72% of parents oppose adolescent contraceptive use, citing religious doctrines that equate such support with moral transgression (Alomair et al., 2023). Conversely, Scandinavian countries like Sweden emphasize collaborative parent-adolescent SRH dialogues, with 65% of parents supporting confidential contraceptive services to reduce unintended pregnancies (Brittain et al., 2018). In the United States, Zeglin and Lazebnik (2023) reported that only 40% of parents endorse contraceptive access for unmarried adolescents, driven by distrust in healthcare systems and concerns about undermining abstinence-based values. These global trends underscore the tension between cultural conservatism and rights-based SRH frameworks.

Across sub-Saharan Africa, parental disapproval remains a critical barrier. In Uganda, a study in informal settlements found that 69% of parents associated contraceptives with promiscuity, often withholding consent for adolescent access due to socio-economic pressures and stigmatization of unmarried sexually active youth (Mulubwa et al., 2021). In Ghana, community health worker outreach programs increased contraceptive use by 5.9% in rural areas, yet parental resistance persisted due to fears of infertility and cultural norms prioritizing early marriage (Henry et al., 2020). A Nigerian study by Janet (2017) revealed that while 79.1% of parents acknowledged adolescents' sexual activity and had basic knowledge of modern contraceptives, their willingness to support contraceptive use was low. Key barriers included fears of promoting promiscuity, concerns about side effects, and adherence to conservative cultural/religious beliefs that equate contraception with moral decay. Similarly, a qualitative study in Malawi by Dombola et al. (2021) found that parents in urban Lilongwe viewed contraceptives as "bad things" and avoided discussing sexuality with adolescents, fearing it would encourage premarital sex. Many parents prioritized abstinence education over contraceptive awareness, leaving adolescents ill-equipped to make informed decisions. These findings align with regional trends where cultural taboos and religious doctrines often overshadow public health messaging on adolescent reproductive health (WHO, 2018). These studies highlight the pervasive influence of religiosity and patriarchal norms in shaping parental attitudes.

In Zambia, parental perceptions are deeply influenced by urbanization, poverty, and cultural traditions. Patriarchal norms, particularly among the Bemba and Tonga ethnic groups, further marginalize adolescent autonomy, as communal decision-making prioritizes elders' views (Phiri et al., 2023). A 2024 national study demonstrated rural-urban disparities: 13.7% of rural parents supported contraceptive use compared to 9.8% in urban areas, with rural resistance tied to limited health literacy and field worker outreach inefficiencies (Sserwanja et al., 2022). Additionally, a 2023 qualitative study by Jacobs et al. (2023) found that married adolescents faced fewer barriers to SRH access than their unmarried peers, reflecting societal prioritization of marital legitimacy over health rights. These findings underscore the need for culturally tailored interventions to address Zambia's stagnant adolescent CPR of 23% (Chola et al., 2020).

2.2 Parents' Knowledge About Adolescent Sexuality and Contraceptives

Parental knowledge and communication practices significantly influence adolescent contraceptive use, yet cultural, educational, and systemic barriers often hinder effective dialogue. A study by Mardi et al. (2018) in Iran explored factors affecting contraceptive use among teenage girls, revealing that parental education levels and cultural taboos shaped perceptions of adolescent sexuality. Despite high teenage fertility rates, contraceptive use remained low due to parental reluctance to discuss sexual health. Families often viewed conversations about contraception as taboo, with parents fearing that such discussions would encourage promiscuity. Additionally, embarrassment, lack of knowledge, and poor communication skills limited mothers' ability to engage adolescents in meaningful dialogue about reproductive health (Mardi et al., 2018). In the United States, a longitudinal study using the National Longitudinal Survey of Adolescent to Adult Health (Add Health) revealed that adolescents with accurate condom knowledge and favourable attitudes toward contraception were more likely to use effective contraceptive methods in adulthood. However, parental discomfort in discussing sexual issues often led to superficial or fear-based communication, limiting adolescents' practical understanding of contraception (Guzzo and Hayford, 2018). Similarly, in Latin America and the Caribbean, a cross-regional review of Demographic and Health Surveys by de Leon et al. (2019) highlighted that contraceptive use among married adolescents in Latin America and the Caribbean was higher than among unmarried peers, reflecting cultural norms that prioritize marital fertility planning. However, knowledge gaps persisted, with many parents conflating abstinence-based messaging with comprehensive contraceptive education. In India, a study by Singh et al. (2020) noted that conservative socio-cultural norms often associate contraceptive use with premarital sexual activity, leading parents to avoid discussions about modern methods. Instead, they emphasized abstinence, resulting in adolescents relying on peers or informal sources for incomplete information.

A multi-country study in Burkina Faso, Ghana, Malawi, and Uganda found that while 96.9% of Nigerian parents were aware of contraceptives, only 31.7% supported adolescent use. In Ghana, pregnant adolescents were five times more likely to rely on ineffective traditional methods (e.g., withdrawal) due to misconceptions about modern contraceptives causing infertility (Onivogui et al., 2024). Research in Narok

and Homa Bay Counties in Kenya revealed that parents often deferred contraceptive education to community elders or religious leaders, framing discussions around moral decay rather than health. This led to adolescents perceiving contraceptives as tools for marital infidelity rather than pregnancy prevention (Atuhaire et al., 2021). Additionally, in South Africa, a baseline survey in Soweto and Khayelitsha showed that only 17% of adolescents knew about emergency contraception, and 50% misunderstood how to use oral contraceptives. Parents' reliance on outdated myths (e.g., condoms reducing sexual pleasure) exacerbated these gaps (Pleaner et al. 2022).

A scoping review across 16 African countries found that parent-adolescent communication often avoided "sensitive" topics like condom use. Discussions were triggered by visible puberty or risky behaviour, but content remained moralistic, lacking practical guidance on contraceptive access (Agbeve, A.S., Fiaveh, D.Y. and Anto-Ocrah, M., 2022). Ehiaghe and Barrow (2022) conducted a cross-sectional study of 360 Nigerian parents and found high levels of contraceptive knowledge (95%) but extremely low willingness (31.7%) to support unmarried adolescents' access. Similarly, a study by Svodziwa et al. (2016) in Zimbabwe highlighted the critical role of parents as primary socializing agents in adolescents' sexual and reproductive health (SRH) transitions. While parents expressed concern for their children's well-being, traditional norms and inadequate SRH knowledge constrained their ability to provide supportive environments.

In Zambia, a 2020 study using Zambia Demographic and Health Survey data found that only 36.8% of parents in Chawama demonstrated adequate contraceptive knowledge. Misconceptions about side effects (e.g., hormonal methods causing infertility) were prevalent, particularly among those with primary education or lower (Munakampe et al., 2021a). Similarly, a mixed-methods study in Chongwe and Luwingu districts by Chola et al. (2023b) revealed that parents often equated contraceptive use with promiscuity, discouraging open dialogue. Adolescents relied on peer educators or health facilities for information, but stockouts and provider bias limited access to reliable resources.

2.3 Parents' Attitude and Beliefs Toward Adolescent Sexuality and Contraceptive Use

Parental attitudes toward adolescent contraceptive use vary significantly across global contexts, influenced by cultural, religious, and socio-economic factors. In India, a mixed-methods study by Singh et al. (2020) found that 78% of parents opposed adolescent contraceptive access, associating it with premarital sexual activity and moral corruption, reflecting deeply entrenched patriarchal norms. In Saudi Arabia, Faidah et al. (2020) reported that 68% of parents rejected contraceptive education for adolescents, citing Islamic principles that prioritize abstinence until marriage. Conversely, in Sweden, a survey by van Wees et al. (2021) revealed that 72% of parents supported confidential adolescent access to contraceptives, attributing this to comprehensive sex education policies and gender-equitable social norms. These studies highlight how cultural and policy environments shape parental acceptance of adolescent contraceptive use.

Across sub-Saharan Africa, parental resistance to adolescent contraceptive use is driven by cultural stigma and misconceptions. In Nigeria, 96.9% of parents are aware of contraceptives, but only 24.2% support adolescent use, citing fears of infertility and religious disapproval (Janet, 2017). In Kenya, Mwaisaka et al. (2020) documented that 65% of rural parents associated contraceptives with infertility, particularly long-acting methods like implants, perpetuating myths rooted in traditional health beliefs. In Ghana, a qualitative study by Nketia (2022) revealed that parents avoided discussing contraceptives with adolescents to avoid "giving permission" for sexual activity, prioritizing abstinence-based approaches. In South Africa, Mukondwa and Gonah (2016) reported that parental disapproval was tied to generational mistrust of healthcare systems, with 60% of parents in KwaZulu-Natal believing contraceptives harm adolescents' future fertility. These findings underscore the interplay of cultural conservatism, misinformation, and healthcare scepticism in shaping African parental attitudes.

In Zambia, parental attitudes are shaped by a blend of urbanization, cultural traditions, and limited SRH literacy. A qualitative study in Lusaka by Chola et al. (2023b) revealed that parents often deferred contraceptive decisions to community elders, fearing social ostracization if they supported adolescent autonomy. In rural Eastern Province, Sserwanja et al. (2022) reported that 63% of parents equated

contraceptive use with "modern immorality," particularly opposing access for unmarried girls. Conversely, in Copperbelt Province, an analysis of the Zambia Demographic and Health Survey by Simamuna (2020) found that educated parents in urban areas were 30% more likely to support contraceptive use, emphasizing the role of socio-economic status in shifting attitudes. These studies illustrate Zambia's complex landscape of parental beliefs, where tradition and modernity collide.

2.4 Parental-adolescent sexuality and contraceptive communication

Parental involvement in adolescent SRH communication plays a pivotal role in shaping access to contraceptive services and reducing adverse outcomes such as unintended pregnancies and STIs (Gatheru et al., 2024). However, global evidence reveals significant disparities in how parents engage with adolescents on these topics, influenced by cultural norms, socioeconomic factors, and systemic barriers. In Nepal, a school-based cross-sectional study by Bhatta et al. (2021) found that adolescents aged 15–19 who reported higher levels of parent–adolescent SRH communication were significantly more likely to utilize adolescent-friendly health services. Notably, students who had engaged in sexual activity within the past year showed greater service uptake, highlighting the role of lived experience in motivating health-seeking behaviour. Ethnic disparities were also evident: Janajati adolescents were more likely to access services compared to Brahmin/Chhetri groups, while those living independently faced reduced access compared to peers residing with both parents. These findings underscore the interplay between familial support, cultural context, and structural barriers in determining SRH outcomes (Bhatta et al., 2021).

Conversely, a United States-based qualitative study by Durante et al. (2023) revealed that many parents delay discussions about contraception until they perceive their children as sexually active, often citing age, physical development, or emotional maturity as decision-making criteria. While some parents expressed fears that discussing contraception might encourage early sexual activity, others recognized its potential to mitigate pregnancy risks. A critical insight from this study was the role of healthcare providers as mediators: parents overwhelmingly trusted paediatricians to initiate confidential, non-judgmental conversations about contraception before sexual debut, bridging gaps in home-based communication.

In Latin America, a scoping review by Buitrago et al. (2023) highlighted systemic inequities in SRH access for Indigenous adolescents, exacerbated by poverty, discrimination, and intergenerational knowledge gaps. Parents, though acknowledged as key information sources, often lacked adequate SRH education themselves, limiting their capacity to guide adolescents. This aligns with findings from Zambia, where Haakonde et al. (2018) found that parents—particularly male lecturers—were reluctant to provide SRH education at home, preferring external educators. Alarmingly, adolescents who received SRH guidance from parents were less likely to engage in promiscuous behaviour, suggesting that proactive communication could serve as a protective factor. However, cultural taboos and gendered expectations (e.g., female lecturers investing more time in SRH discussions) perpetuated inconsistent messaging.

Collectively, these studies illustrate a recurring tension between parental intentions to protect adolescents and sociocultural barriers that hinder open SRH dialogue. While parents universally value SRH education, their willingness to engage is often mediated by fears of enabling sexual behaviour, limited knowledge, or systemic exclusion of marginalized groups. Interventions must address these intersecting challenges through culturally sensitive strategies, such as training healthcare providers to act as SRH communication bridges and empowering parents with accurate, age-appropriate information.

2.5 Identified Gaps and Conclusion

The literature review highlighted several gaps in the existing literature on parents' perceptions towards adolescents' use of contraceptives. Firstly, there was a lack of studies that specifically focus on the cultural, social, and economic factors influencing parental perceptions in this context. Secondly, there was a need for more nuanced exploration of the communication dynamics between parents and adolescents regarding sexual health. Lastly, there is a gap in understanding the impact of parental perceptions on adolescents' access to and use of contraceptives. The current study aimed to address these gaps by providing empirical evidence on the factors influencing parental perceptions toward adolescents' use of contraceptives. The study explored intrapersonal and interpersonal factors at play, examining the communication dynamics between parents and adolescents. The literature review

underscored the importance of understanding parents' perceptions towards adolescents' use of contraceptives in Chawama Township, Lusaka, Zambia. It highlighted the need for interventions that are culturally sensitive, community-based, and inclusive of parents and guardians. By addressing the identified gaps in the literature, the study aimed to contribute to the development of effective strategies that improve adolescents' access to and use of contraceptives, ultimately enhancing their sexual and reproductive health outcomes.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

This chapter outlined the methodology used for the study. The chapter detailed the research design, study setting, population, sampling techniques, data collection tools, data analysis methods, and ethical considerations. The primary goal was to provide a comprehensive framework that ensures the study's objectives were met with rigor and validity.

3.1 Study Design

The study employed a descriptive cross-sectional survey design. This design was chosen because it allowed for the collection of data at a single point in time, making it suitable for assessing the current perceptions of parents towards adolescents' use of contraceptives. The descriptive cross-sectional design was particularly appropriate for this study as it enabled the researcher to gather a snapshot of parental perception, attitudes, and knowledge within a specific timeframe without changing or altering any variables. Additionally, it was cost-effective and less time-consuming compared to longitudinal studies, which was beneficial given the resource constraints.

3.2 Study Setting

This study was conducted in Chawama Townships of Lusaka. It is located 12 km north south of the Capital city of Lusaka. The population is about 68,343 according to year 2010 population Census. Most of the people are in informal employment with majority of the population being youthful. The commonest religion is predominantly Christianity, although there few Muslims coming up. Chawama is one of the largest and most populous townships in Lusaka, characterized by a diverse demographic profile that includes a mix of low-income and middle-income households. The township is known for its vibrant community life and is home to a substantial number of adolescents and their families.

Chawama Township was an ideal setting for this study due to several factors. Firstly, it has a high concentration of adolescents, making it a relevant location for researching issues related to adolescent sexual and reproductive health. Secondly, the township is served by several health facilities, including clinics and a general hospital

(Chawaman First Level Hospital), which provide sexual and reproductive health services, including contraceptives. These facilities are accessible to the local population, although utilization rates and perceptions of these services can vary widely.

The socio-economic conditions in Chawama are diverse, with some families experiencing significant economic challenges, which can influence access to healthcare and attitudes towards contraceptive use. The cultural and social dynamics of the township, including traditional beliefs and practices (Ndhlema, 2015), also play a crucial role in shaping parental perceptions and behaviours related to adolescent sexuality and contraceptive use. Thus, Chawama Township's unique characteristics, including its demographic diversity, existing health infrastructure, community networks, and socio-economic conditions, made it a suitable and relevant setting to study parents' perception towards adolescents' use of contraceptives.

3.3 Study Population

The study population were parents in Chawama Township cut across all social strata, religious affiliation and marital status at the time of the study.

3.4 Target Population

The target population was parents of adolescents in selected households of Chawama Township who had adolescents in their households.

3.5 Sampling Technique

The study employed a simple random sampling method to select participants from the target population. Specifically, we used simple random sampling without replacement to ensure that each participant has an equal probability of being selected and that no individual is chosen more than once. House numbers and locations were obtained from the Local Housing Office in Chawama. The house numbers were then subjected to random selection to pick houses. When houses were identified, they were subjected to the inclusion criteria to pick parents who had adolescents in their homes for interviews. Consent was then obtained and parents who accepted were interviewed using a pre-tested researcher-administered interview schedule. The

process was repeated on each day of interviewing until the desired number of respondents was reached.

This sampling method was use because simple random sampling ensured that every parent or guardian in the target population had an equal chance of being included in the study. This method minimized selection bias and enhanced the representativeness of the sample, allowing for more generalizable results. This sampling technique was straightforward to implement, especially when a complete and accurate sampling frame (a list of all parents or guardians in Chawama Township) was available. The process involved randomly selecting participants from the list without any additional stratification or clustering. By using sampling without replacement, the study eliminated the possibility of selecting the same individual multiple times. This approach was more efficient and prevented overrepresentation of certain individuals or households in the sample. Lastly, simple random sampling without replacement is a well-established method that provides a solid foundation for statistical inference. It allows for the application of standard statistical techniques to analyse the data, ensuring the validity and reliability of the study's findings.

3.6 Eligibility Criteria

3.6.1 Inclusion criteria

1. Parents or guardians of adolescents aged 10-19 years.
2. Residents of Chawama Township.
3. Willingness to participate in the study

3.6.2 Exclusion criteria

1. Parents or guardians who are not the primary caregivers of the adolescent.
2. Parents or guardians with established mental disabilities or ill at the time of the study.

3.7 Sample Size

Sample size was calculated using the Cochrane’s formula (1977). In this study, the researcher set the value of the maximum proportion at 50% since the population was drawn from an infinite sample. With a 95% confidence interval, a 6.25% precision

either side of the population estimate was used. The sample was determined as follows:

$$n = \frac{Z^2 pq}{d^2}$$

Z = 1.96 the standard normal variate at 95% confidence level

d = 6.25% the margin of error or precision based on time and resources.

p = is the estimated proportion of parents not allowing their children to use contraceptives in the population, set at the maximum variability = 50% (0.5).

$q = 1 - p$

$$n = \frac{(1.96)^2(0.5)(1-0.5)}{(0.0625)^2} = \frac{0.9604}{0.00330625} = 246$$

Assuming a 5% non-response rate, the study sampled 258 respondents to participate in the study.

3.8 Data Collection Tool

Data was collected using a structured questionnaire. The questionnaire was designed to capture participants' sociodemographic information contained in section A, parents' knowledge about adolescent sexuality and contraceptives contained in section B, their attitudes and beliefs towards contraceptive use contained in section C, their communication with adolescents about sexual health in section D, and their perception toward adolescents' use of contraceptives contained in section E. The questionnaire were developed based on existing literature (Widman et al., 2016; Kirby, 2002; WHO, 2018; Aspy et al., 2007), ensuring content validity and reliability.

3.9 Data Collection Technique

Individual face to face interviews were conducted with the respondents within participants' residence. All interviews were manually recorded with the permission of the respondents and lasted about 45 minutes. All respondents were given basic information about the study before consent was obtained. The identities of the respondents and the information they provided were treated as confidential. The researcher conducted a maximum of ten interviews per day in order to be effective. To avoid possible language barriers, the questionnaires were verbally translated into

the local language during administration, and were administered as an interview by the researcher.

3.10 Validity and Reliability

The questionnaire was subjected to scrutiny on the subject matter by experts at the school of nursing to establish face and content validity. Validity was also measured by ensuring that the same questions were asked to each respondent in the same sequence. Questions were clearly constructed to avoid ambiguity. Content validity was ensured by covering all the variables under study in the interview schedule and questionnaires. The supervisors also reviewed the questionnaire and provided expert advice.

Reliability of the instrument was measured by conducting a pilot study and subjecting the study instrument different respondents. Further the questionnaire was interpreted in one of the local languages (Nyanja) and tested for consistence in meaning and response to questions. The results from the pilot study were used as base line data to test reliability. In addition, Cronbach alpha test was also done and a score of 0.70 was considered appropriate.

3.11 Pilot Study

A pilot study was conducted with a small sample of parents or guardians (approximately 26 (10% of the final sample size)) to test the questionnaire and data collection procedures. It was conducted at Matero Level I Hospital in Lusaka which has similar characteristics with the study setting for the main study. The pilot study was done to ensure that the questions were clear to the participants and reviewed for validity and reliability. The sample for the pilot study was similar to the main study, however, this was not included in the actual study. After the pilot study necessary adjustments were made to section B of the data collection tool relating to knowledge and the simplified versions of questions are reflected in the final tool.

3.12 Data Processing and Analysis

Data verification and validation was performed by rechecking all data entries with the original data forms to achieve a clean dataset that was exported into a Statistical Package for social sciences (SPSS) version 27.0. Data analysis involved descriptive

and inferential statistics. Findings were presented according to the sequence of questions and sections of the questionnaires. Numerical data was presented as raw figures and percentages, and in form of bar charts, pie charts and frequency and cross tabulation tables for easy understanding. Pearson's Chi square (or Fisher's exact) statistical tests were used to determine the association between dependent and independent variables. Bivariate and multivariate logistic regression was conducted to determine the factors associated with parents' perception on adolescent contraceptive use. Both crude odds ratios (COR) and adjusted odds ratios (AOR) were determined and variables with p-value < 0.05 at 95% confidence interval on multivariable logistic regression was considered statistically significant.

3.13 Ethical Considerations

Ethical clearance to conduct the study was obtained from the University of Zambia Biomedical Research Ethics Committee (Appendix VI) and permission to conduct health research was obtained from the National Health Research Authority (Appendix VII). Letters of introduction was obtained from the area counsellor to conduct the study as cover for confidentiality and trust.

On the day of administering the questionnaires, the purpose and importance of the study were explained to the respondents and the reasons they were required to take part in the study. The respondents were not coerced or forced in any way to participate in the study. Finally, the findings of the study were reported as obtained without changing, altering or falsifying them. Each respondent was given a participant information sheet and informed consent verbally obtained on the aim of the study, assured of their anonymity and confidentiality of information when analysing the data and discussing the findings.

Confidentiality was assured, that is, their names were not known and whatever information they gave was only used for the study. The hard copies containing the responses were stored under lock and key in a secure cabinet for reference until the report was done and findings disseminated. After approval and publishing of the study, information will be shredded for disposal.

CHAPTER FOUR: PRESENTATION OF RESULTS

4.0 Introduction

This chapter presents the results of data analysis and interpretation of the findings. The analysed information was summarized and presented using tables in line with objectives which were to (1) determine the level of parental perception toward adolescents' use of contraceptives, (2) examine the influence of parental knowledge of contraceptives on their perception towards adolescents' use of contraceptives, (3) determine the influence of parental attitudes on their perception towards adolescents' use of contraceptives, and (4) explore the influence of communication patterns between parents and adolescents on their perception level in Chawama township of Lusaka. The chapter first presents the descriptive statistics and ends with presenting inferential statistics with corresponding p-values for associations between independent and dependent variables considered.

4.2 Presentation of Results

A total 239 respondents out of 258 successfully surveyed were included in the analysis, with 19 cases who fell out of the study. This indicated a 92.6% response rate. This section presents descriptive statistics of the respondents.

4.2.1 Socio-demographic characteristics

The socio-demographic characteristics of the respondents are presented in table 4.1.

Table 4.1 shows that majority (77.4%) of the respondents were female with most of them aged 24 – 40 years (60.3%). Over half (56.5%) of respondents were married, with a about a third (37.2%) of them had primary level education. About two-fifth (45.2%) of respondents were unemployed, and most (62.8%) of them had 2 to 4 children. Nearly all (96.7%) of the respondents were Christians; slightly over a third (34.3%) of the respondents were of the eastern tongue (belonged to the Chewa, Ngoni, Nsenga and Tumbuka tribes). Thus, the demographic data reveals that the majority of respondents were married Christian women between the ages of 24 and 40, with primary education and 2 to 4 children, and nearly half were unemployed. Additionally, a significant proportion of the respondents were from ethnic groups originating from the eastern part of Zambia, indicating a diverse cultural representation within the study population.

Table 4. 1: Respondent's socio-demographic characteristics (n=239)

Variable	Frequency	Percent
Age (years)		
24 – 40	144	60.3
41 – 77	95	39.7
Gender		
Male	54	22.6
Female	185	77.4
Marital status		
Married	135	56.5
Unmarried	104	43.5
Education		
No formal education	26	10.9
Primary	89	37.2
Secondary	88	36.8
Tertiary	36	15.1
Occupation		
Employed	34	14.2
Business	97	40.6
Unemployed	108	45.2
Number of children		
1	24	10
2 – 4	150	62.8
5 – 10	65	27.2
Religion		
Christian	231	96.7
Muslim	8	3.3
Tribe		
Bemba	60	25.1
Chewa/Ngoni/Nsenga/Tumbuka	82	34.3
Tonga/Lenje/Ila	42	17.6
Lozi	18	7.5
Other	37	15.5

4.2.2 Parents' perception-related characteristics

The perception-related characteristics of the respondents are presented in table 4.2.

Table 4. 2: Respondents' perception-related characteristics

Variable	Frequency	Percent
Perceived users of contraception*		
Only the married	96	13.1
Singles only	141	19.3
Females only	177	24.2
Males only	142	19.4
Both males and females	176	24
Perceived dangers of unprotected sex to adolescents*		
Unwanted pregnancies	231	24.4
Abortions	180	19
STIs/HIV/AIDS	218	23
Infertility	100	10.6
Preferred contraceptive for adolescent*		
Condoms	189	18.1
Diaphragm	19	1.8
IUD	67	6.4
Microgynon	115	11
Noristaret	106	10.1
Depo Provera	131	12.5
Withdrawal	58	5.5
Traditional	36	3.4
Breastfeeding	65	6.3
Sterilisation	35	3.3
BTL	31	3
Implants	100	9.6
Jadelle	94	9
Overall Perception Level		
Positive	116	48.5
Negative	123	51.5

Multiple entries

Table 4.2 shows that, concerning perceived users of contraceptives, about a quarter (24.2%) of the respondents indicated that contraceptives can be used by females only; 24% indicated that it can be used by both male and females. Similarly, concerning the perceived dangers of unprotected sex among adolescents, about a quarter (24.4%) of the respondents indicated that unprotected sex is risk for unwanted pregnancies. Concerning the preferred type of contraceptives for adolescents, the most preferred type of contraceptives parents could recommend to adolescents were condoms (18.1%). These results indicate a lack of consensus among respondents regarding who can use contraceptives, with nearly equal proportions believing they are for females only, both males and females, males only, or singles. Additionally, there is a notable variation in perceived risks of unprotected sex, with unwanted pregnancies and STIs/HIV/AIDS being the most frequently cited concerns, and condoms emerging as the most preferred contraceptive method among adolescents.

Overall, the results on parents' perception indicate that a slight majority of respondents (51.5%) hold a negative perception towards adolescents' use of contraceptives, suggesting that negative perception are more prevalent than positive ones in the study population. Conversely, just under half of the respondents (48.5%), have a positive perception, indicating a relatively balanced but marginally unfavourable overall perception towards adolescent contraceptive use. (See table 4.2)

4.2.3 Knowledge-related characteristics

The knowledge-related characteristics of the respondents are presented in table 4.3.

Table 4.3 shows that, concerning the meaning of contraceptives, about a quarter (24.8%) of the respondents indicated that contraceptives were for spacing children. Concerning the benefits of contraceptives, nearly two-fifth (38.8%) of the respondents indicated that contraceptives help prevent pregnancy. Concerning the source of knowledge information, less than a quarter (21%) of respondents indicated that health workers were their source of information. The results indicate a diverse understanding of contraceptives among respondents, with varying perceptions of their purpose, benefits, and side effects. Additionally, the primary sources of information about contraceptives are health facilities and social networks, including friends and partners, highlighting the importance of these channels in shaping contraceptive knowledge.

Table 4. 3: Respondents' knowledge-related characteristics

Variable	Frequency	Percent
Meaning of contraceptives*		
Method of preventing pregnancy	222	24.4
Method of terminating pregnancy	25	2.7
Methods of preventing STIs	107	11.8
Method of controlling family size	214	23.6
Method of spacing children	226	24.8
Methods of increasing sexual pleasure	116	12.7
Benefits of contraceptives*		
Sexual pleasure	133	22.6
Prevention of pregnancies	228	38.8
Prevention of STIs	124	21.1
Prevention of abortion	103	17.5
Side effects of contraceptives*		
They are harmful	93	7.8
The cause weight gain	201	16.8
They cause weight loss	169	14.2
Condoms burst	187	15.7
Heavy periods	188	15.8
No periods	161	13.5
Irregular periods	146	12.2
Infertility	48	4
Source of information*		
Clinics or hospitals	232	21
TV/Radio	174	15.7
Social media	143	12.9
Newspapers	88	7.9
Friends	209	18.9
Partner	169	15.3
Church/mosque	92	8.3
Overall Knowledge Level		
Adequate knowledge	88	36.8
Average knowledge	104	43.5
Inadequate knowledge	47	19.7

Multiple entries

Overall, the results on parental knowledge level indicate that a significant proportion of respondents (43.5%), possess an average level of knowledge about contraceptives, suggesting a moderate level of awareness. However, only 36.8% of respondents have adequate knowledge, while nearly one-fifth (19.7%) have inadequate knowledge, highlighting a need for improved education and awareness programs on contraceptive use. (See table 4.3)

4.2.4 Parental attitudes and beliefs characteristics

The attitude and beliefs-related characteristics of the respondents are presented in table 4.4.

Table 4. 4: Respondents' attitude and beliefs-related characteristics (n=239)

Variable	Frequency	Percent
Parents' control on use of contraceptives		
Agree	152	63.6
Disagree	87	36.4
Adolescents' use of contraceptives against parental advice and knowledge		
Agree	144	60.3
Disagree	95	39.7
Unmarried adolescents use of contraceptives		
Agree	75	31.4
Disagree	164	68.6
Parental collection of contraceptives		
Agree	70	29.3
Disagree	169	70.7
Procure contraceptives for adolescent		
Agree	47	19.7
Disagree	192	80.3
Refer sexually active adolescent to SRH clinic		
Agree	96	40.2
Disagree	143	59.8
Allow adolescent to buy contraceptives		
Agree	60	25.1
Disagree	179	74.9
Rebuke adolescent for using contraceptives		
Agree	141	59
Disagree	98	41
Overall Attitudes and Beliefs		
Positive	78	32.6
Negative	161	67.4

Table 4.4 showed that a significant level of parental control (63.6%) and disapproval regarding adolescents' use of contraceptives (59%), with a majority of respondents asserting their authority and expressing reluctance to facilitate access to contraceptives (63.6%, 74.9%, respectively). Conversely, there is a notable resistance to allowing unmarried adolescents to use contraceptives (68.6%), as evidenced by the high percentages of disagreement with actions such as purchasing (80.3%) or

collecting contraceptives (70.7%), and referring sexually active adolescents to health facilities for sexual and reproductive health services (59.8%).

Overall, the results on parental attitudes indicate that a significant majority of respondents, 67.4%, hold negative attitudes towards contraceptives, suggesting a widespread reluctance or opposition to their use. Conversely, only 32.6% of respondents exhibit positive attitudes, highlighting a potential barrier to effective contraceptive adoption and utilization within the studied population. (See table 4.4)

4.2.5 Parent-adolescent communication-related characteristics

The communication-related characteristics of the respondents are presented in table 4.5.

Table 4. 5: Respondents' communication-related characteristics (n=239)

Variable	Frequency	Percent
Support talking about contraceptives to unmarried adolescent		
Agree	111	46.4
Disagree	128	53.6
Free to talk about contraceptives unmarried adolescent		
Agree	98	41
Disagree	141	59
Only males to use contraceptives		
Agree	35	11.6
Disagree	204	85.4
Use of contraceptives encourages promiscuity		
Agree	113	47.3
Disagree	126	52.7
Adolescents' use is against culture and religion		
Agree	96	40.2
Disagree	143	59.8
Overall SRH Communication		
Supportive	136	56.9
Poor	103	43.1

Table 4.5 reveal a divided stance among respondents regarding communication about contraceptives with their adolescent children, with a slight majority opposing such discussions and feeling uncomfortable engaging in these conversations (53.6%). Additionally, while a significant proportion of respondents do not support their children's use of contraceptives due to cultural or religious beliefs (59.8%), there is a

notable divide in perceptions regarding the association between contraceptive use and promiscuity (52.7% vs. 47.2%), as well as the gender-specific use of contraceptives (85.4%).

Overall, the results indicate that a slight majority of respondents (56.9%) reported having supportive and open communication with adolescents regarding SRH. However, a significant proportion (43.1%) still demonstrated poor communication practices, highlighting a need for improvement in parental-adolescent dialogue about SRH topics. (See table 4.5)

4.3 Factors Associated with parents' perception on adolescent contraceptive use

This section presents the result of chi-square and Fishers' exact tests in form of cross-tabulation tables with corresponding p-values.

Table 4. 6: Demographics' characteristics associated with perception (n=239)

Variable	**Parent's perception (%)**		**P-value**
	Positive	**Negative**	
Age (years)			0.188*
24 – 40	75 (52.1)	69 (47.9)	
41 – 77	41 (43.2)	54 (56.8)	
Gender			0.643*
Male	28 (51.9)	26 (48.1)	
Female	88 (47.6)	97 (52.4)	
Marital status			0.897*
Married	65 (48.1)	70 (51.9)	
Unmarried	51 (49)	53 (51)	
Education			**<0.001**
No formal education	6 (23.1)	20 (76.9)	
Primary	36 (40.4)	53 (59.6)	
Secondary	47 (53.4)	41 (46.6)	
Tertiary	27 (75)	9 (25)	
Occupation			**0.002**
Employed	26 (76.5)	8 (23.5)	
Business	41 (42.3)	56 (57.7)	
Unemployed	49 (45.4)	59 (54.6)	
Number of children			0.356
1	11 (45.8)	13 (54.2)	
2 – 4	78 (52)	72 (48)	
5 – 10	27 (41.5)	38 (58.5)	
Religion			0.489*
Christian	111 (48.1)	120 (51.9)	
Muslim	5 (62.5)	3 (37.5)	
Tribe			0.159

Bemba	35 (58.3)	25 (41.7)	
Chewa/Ngoni/Nsenga/Tumbuka	31 (37.8)	51 (62.2)	
Tonga/Lenje/Ila	21 (50)	21 (50)	
Lozi	9 (50)	9 (50)	
Other	20 (54.1)	17 (45.9)	

***Fisher's exact test**

Table 4.6 shows that respondents with tertiary level education ($p < 0.001$) and in employment ($p = 0.002$) were significantly associated with positive perception toward adolescents' use of contraceptive. However, there was no significant association between respondents' age ($p = 0.188$), gender ($p = 0.643$), marital status ($p = 0.897$), number of children ($p = 0.356$), religion ($p = 0.489$), and tribe ($p = 0.159$) with their perception toward adolescents' use of contraceptives.

Table 4. 7: Respondents' characteristics associated with perception level (n=239)

Variable	**Parent's perception (%)**		**P-value**
	Positive	**Negative**	
Knowledge			**<0.001**
Adequate	51 (58)	37 (42)	
Average	57 (54.8)	47 (45.2)	
Inadequate	8 (17)	39 (83)	
Attitudes			**<0.001***
Positive	56 (71.8)	22 (28.2)	
Negative	60 (37.3)	101 (62.7)	
SRH Communication			**<0.001***
Supportive	89 (65.4)	47 (34.6)	
Poor	27 (26.2)	76 (73.8)	

***Fisher's exact test**

Table 4.6 shows that respondents with adequate level of knowledge ($p < 0.001$), positive attitude ($p < 0.001$), and supportive SRH communication ($p < 0.001$) were significantly associated with positive perception toward adolescents' use of contraceptive.

Multivariable logistic regression analysis shows that three (3) factors were identified to be significantly associated with good perception toward adolescents' use of contraceptives among respondents.

Table 4.7 shows that parents with average level of knowledge on contraceptives were 4.8 times more likely to have positive perception towards adolescents' use of contraceptives compared to those with inadequate knowledge level [AOR: 4.8; 95%

CI: 1.5–10.2; p = 0.006]; while parents with adequate knowledge level on contraceptives had a 3.9-fold likelihood of having positive perception compared to their counterparts with inadequate knowledge level [AOR: 3.9; 95% CI: 1.8–12.4; p = 0.001]. Also, parents with positive attitudes toward contraceptives were 3.3 times more likely to have positive perception toward adolescents' use of contraceptives compared to parents with negative attitudes toward contraceptives [AOR: 3.3; 95% CI: 1.7–6.4; p < 0.001]. Further, parents with supportive SRH communications were 4.4 times more likely to have positive perception on adolescent contraceptive use relative to those with poor SRH communication [AOR: 4.4; 95% CI: 2.3–8.4; p < 0.001].

Table 4. 8: Predictors of parents' perception towards contraceptives (n=239)

Variable	COR (95% CI)	P-value	AOR (95% CI)	P-value
Education				
No formal education	Ref			
Primary	2.4 (0.8-6.2)	0.111	1.3 (0.4-4.2)	0.662
Secondary	3.8 (1.4-10.4)	**0.009**	2.7 (0.8-8.5)	0.098
Tertiary	10.0 (3.1-32.7)	**<0.001**	2.9 (0.6-12.9)	0.164
Occupation				
Employed	3.9 (1.6-9.4)	**0.002**	1.3 (0.4-4.1)	0.605
Business	0.9 (0.5-1.5)	0.655	0.7 (0.4-1.3)	0.254
Unemployed	Ref			
Knowledge				
Adequate	6.7 (2.8-16.0)	**<0.001**	3.9 (1.5-10.2)	**0.006**
Average	5.9 (2.5-13.9)	**<0.001**	4.8 (1.8-12.4)	**0.001**
Inadequate	ref			
Attitudes				
Positive	4.3 (2.4-7.7)	**<0.001**	3.3 (1.7-6.4)	**<0.001**
Negative	ref			
SRH Communication				
Supportive	5.3 (3.0-9.4)	**<0.001**	4.4 (2.3-8.4)	**<0.001**
Poor	ref			

CHAPTER FIVE: DISCUSSION FINDINGS

5.0 Introduction

Parents are key players in adolescent reproductive health and the roles of parents in delaying the age of sexual initiation and in the uptake of contraceptives have been well documented (Janet, 2017). This study therefore assessed the perception of parents on adolescents' use of contraceptive in Chawama township of Lusaka, Zambia. This chapter discusses the key findings of the study based on the study objectives. It also presents the implications, recommendations and conclusions and limitations of the study.

5.1 Sociodemographic Characteristics of Respondents

The demographic distribution of the respondents in this study provides a comprehensive overview of the community's characteristics (Table 4.1 page 25). The majority of respondents were aged 31-40 years (39.7%), predominantly female (77.4%), married (56.5%), with primary level education (37.2%), unemployed (45.2%), and having 2-4 children (62.8%). These demographics are crucial in understanding the perceptions of parents towards adolescent contraceptive use. The religious affiliation of respondents, with a significant proportion being Christians, particularly Pentecostals (28.9%) and Catholics (22.6%), reflects the religious landscape of Chawama Township. While, the ethnic distribution of respondents, with the majority being from the Bemba tribe (25.1%), followed by Tonga (13.8%) and Chewa (11.7%), is reflective of the ethnic composition of the region.

Similar findings were reported by Janet (2017) in Nigeria where 67.3% of their respondents were females, 33.6% fell within 30-39 years age group and 49.1% within 40-49 age group. Eighty percent (80.9%) practiced Christianity, and 83.6% were married. However, her study found that 70.0% of the respondents had tertiary education (Janet, 2017). Similarly, Oyediran and Joel (2013) reported that their study found 36.0% of the respondents were within the age range of 31 and 40 years, more than half (65.0%) of the respondents were female and almost all (90%) the respondents were married; according to the religion inclination 72.5% of them were Christian. However, their results on education and occupation were contrary to the present study, they reported that 85.0% of the respondents were civil servants, and 259 (62.3%) of the respondents attended tertiary institutions (Oyediran and Joel,

2013). Also, Ehiaghe and Barrow (2022) reported that of the 360 respondents in their study, 60% were females 66.7% were within the age range of 25-40 years, 60% were married and Christianity (88.3%) was the dominant religion. However, a large proportion (91.4%) were civil servants, and 77.2% had a tertiary level of education (Ehiaghe and Barrow, 2022).

5.2 Parents' perception on adolescent contraceptive use

Overall, 48.5% of respondents had a positive perception of adolescent contraceptive use, while 51.5% had a negative perception. This division highlights the ongoing debate and mixed feelings among parents regarding adolescent contraceptive use. A study in Zambia found that while some parents support contraceptive use to prevent unintended pregnancies, others remain opposed due to cultural and religious beliefs (Simataa, 2017). Similarly, research in Kenya and South Africa has shown that parental perceptions of adolescent contraceptive use are influenced by a complex interplay of cultural, religious, and socio-economic factors (Kinaro et al., 2015; Ntini et al., 2023). Parents' ignorance about SRH may lead to misconceptions passed on to their children, influencing them to make poor sexual choices (Baku, 2012). A study by Biddlecom et al. (2018) in Ghana found that cultural and religious beliefs often led parents to view adolescent contraceptive use as promoting promiscuity, which is similar to the negative perceptions observed in the current study. This suggests that deeply rooted societal norms and values continue to influence parental attitudes across different African contexts.

Conversely, the fact that 48.5% of respondents reported a positive perception indicates a relatively balanced but marginally unfavourable overall perception. This finding is somewhat consistent with research conducted in other parts of the world, where there is a growing trend towards more supportive attitudes among parents. For example, a study by Widman et al. (2016) in the United States found that parents who engaged in open communication with their adolescents about sex and contraception were more likely to have positive perceptions of contraceptive use. This discrepancy between the current study and studies in other regions may be attributed to differences in cultural, social, and religious contexts, as well as variations in access to comprehensive sexual education and healthcare services.

The marginally unfavourable overall perception in the current study could also be influenced by the limited availability of accurate information about contraceptives and their benefits for adolescents. A study by the WHO (2018) emphasizes the importance of providing parents with accurate information to dispel myths and misconceptions about adolescent contraceptive use. In the absence of such information, parents may rely on traditional beliefs and hearsay, which can perpetuate negative perceptions.

Furthermore, the relatively high percentage of respondents with positive perceptions (48.5%) could be attributed to recent efforts by local health organizations and community programs in Zambia to promote sexual and reproductive health education (Jacobs et al., 2023). These initiatives may have contributed to a shift in attitudes among some parents, as evidenced by the growing body of research highlighting the positive impact of community-based interventions on parental perceptions (Lukumay et al., 2023). However, the fact that these positive perceptions do not constitute a majority indicates that more targeted and sustained efforts are needed to change the overall perception. These results reflect a complex interplay of cultural, social, and educational factors influencing parents' perceptions towards adolescents' use of contraceptives. While there is a slight tilt towards negative perceptions, the presence of a significant proportion of positive perceptions suggests that change is possible with continued advocacy, education, and community engagement. This conclusion is supported by studies such as those by Biddlecom et al. (2018) and Widman et al. (2016), which underscore the importance of addressing both cultural barriers and the need for accurate information in shaping parental attitudes towards adolescent contraceptive use.

5.3 Factors associated with parents' perception on adolescent contraceptive use

5.3.1 Knowledge of contraceptives among respondents

The results from the current study have indicated that a noteworthy 36.8% of the individuals who participated in the survey exhibited a commendable level of understanding regarding contraceptives, while an additional 43.5% demonstrated a level of knowledge that could be classified as average, and a further 19.7% were identified as possessing insufficient knowledge on the subject matter. These results align with previous scholarly research that has extensively documented the existence

of disparate levels of contraceptive knowledge among parents, a phenomenon that is significantly shaped by a multitude of factors, including but not limited to educational attainment, socioeconomic standing, and prevailing cultural beliefs, as evidenced in the work of Oyediran and Joel (2018). A series of empirical studies has consistently illustrated that enhancing the knowledge base of parents through meticulously designed educational interventions can yield a favourable impact on the utilization of contraceptives among adolescents, as highlighted by the findings of Ntini et al. (2023). In light of this, the survey conducted revealed that a substantial 58% of parents who possessed an adequate level of knowledge exhibited a marked association with a positive perception regarding adolescent contraceptive use when compared to their counterparts who demonstrated an inadequate level of knowledge, which constituted only 17% of the sample ($p < 0.001$).

Numerous research endeavours substantiate the assertion that possessing adequate knowledge serves as a favourable determinant that positively influences perceptions surrounding the use of contraceptives. For instance, a pertinent study conducted in Kenya revealed that adolescents who were equipped with a comprehensive understanding of contraceptives were significantly more inclined to utilize these methods and harboured more favourable attitudes towards their application, as reported by Kinaro et al. (2015). In a similar vein, research findings from Zambia have indicated that parents who were thoroughly informed about contraceptives were notably more supportive of their adolescent children's engagement with these methods, as documented by Mudenda (2019). Nevertheless, it is essential to acknowledge that contrasting perspectives are presented in a subset of studies. For example, a noteworthy investigation conducted in South Africa uncovered that, despite a substantial level of knowledge regarding contraceptives among parents, many individuals still maintained negative perceptions that were deeply rooted in cultural and religious beliefs, as pointed out by Ntini et al. (2023). This observation underscores the intricate and multifaceted relationship that exists between knowledge and other sociocultural determinants in influencing perceptions of contraceptive use.

5.3.2 Attitudes and Beliefs toward contraceptives

The results on parental attitudes towards contraceptives in this study, where 67.4% of respondents hold negative attitudes, align with broader research indicating

significant resistance to contraceptive use among parents in sub-Saharan Africa. For instance, a study by Biddlecom et al. (2018) in Ghana found that cultural and religious beliefs often lead to negative perceptions of contraceptives, which can deter their acceptance and use. Similarly, in Nigeria, Aliyu and Aransiola (2023) reported that misconceptions and fear of side effects contribute to negative attitudes towards contraceptives, which is consistent with the widespread reluctance observed in the current study. The low percentage of respondents (32.6%) exhibiting positive attitudes further underscores the challenge of promoting contraceptive adoption and utilization within this population.

The association between positive attitudes and perceptions towards adolescents' use of contraceptives is also noteworthy. Parents with positive attitudes were 3.3 times more likely to have a positive perception of adolescents' contraceptive use, as indicated by an Adjusted Odds Ratio (AOR) of 3.3 [95% CI: 1.7–6.4; $p < 0.001$]. This finding is supported by research from Uganda by Namanda et al. (2023), which found that parents with favourable views on contraceptives were more likely to support their use among adolescents. The strong association suggests that interventions aimed at improving attitudes could positively influence perceptions and, consequently, the acceptance of contraceptive use among adolescents.

However, the results contrast with studies conducted in more developed regions. For example, a study in the United States by Guzzo and Hayford (2018) found that parental attitudes towards contraceptives were generally more favourable, with a higher percentage of parents supporting their use among adolescents. This discrepancy may be attributed to differences in cultural, religious, and socio-economic contexts, as well as the availability and accessibility of sexual education and healthcare services. The reasons for the predominantly negative attitudes in the current study could be multifaceted. Firstly, cultural and religious beliefs often play a significant role in shaping attitudes towards sexuality and contraceptive use, as evidenced by studies in similar settings (Biddlecom et al., 2019). Secondly, a lack of comprehensive sexual education may contribute to misconceptions and fear, further reinforcing negative attitudes (Aliyu and Aransiola, 2023). Lastly, socio-economic factors, such as limited access to healthcare and contraceptive services, may also influence parental perceptions (Namanda et al., 2023). The study's results highlight the need for targeted interventions that address the underlying cultural, educational,

and socio-economic factors contributing to negative attitudes towards contraceptives. By promoting open dialogue and providing accurate information, it may be possible to shift perceptions and improve the acceptance of contraceptive use among adolescents in Chawama Township, Lusaka, Zambia.

5.3.3 Parent-adolescent communication

The results of the current study indicating that 56.9% of parents engage in supportive SRH communication with adolescents—while 43.1% exhibit poor dialogue—align with broader trends observed in sub-Saharan Africa. These results reflect both progress and persistent challenges in parental-adolescent SRH communication. The strong association between supportive communication and positive perceptions of contraceptive use (AOR: 4.4; 95% CI: 2.3–8.4) resonates with studies emphasizing parental influence as a critical determinant of adolescent SRH outcomes. In support of this, a 2023 Zambian study found that parents who openly discussed contraceptives were more likely to support their adolescents' autonomy in SRH decisions, reducing stigma and misinformation (Chola et al., 2023b). Similarly, a Nigerian study by Ehiaghe and Barrow (2022) reported that parents with higher SRH literacy were 3.2 times more likely to endorse contraceptive use, underscoring the role of knowledge in shaping attitudes.

However, the persistence of poor communication practices (43.1%) mirrors findings from a 2023 scoping review across sub-Saharan Africa, which identified cultural taboos, patriarchal norms, and fears of promoting promiscuity as entrenched barriers to open dialogue (Chola et al., 2023a). Similarly, in South Africa, parents often avoid SRH discussions to maintain traditional hierarchies, fearing that such conversations might "encourage" sexual activity (Hlongwa et al., 2021). This aligns with the current study's context, where socio-cultural conservatism in Zambia—particularly in communities like Chawama—likely perpetuates reluctance to address SRH topics openly.

The disparity in communication quality may also stem from systemic factors, such as inadequate parental education on SRH. Ehiaghe and Barrow (2022) revealed that while 96.9% of parents knew about contraceptives, only 24.2% held positive attitudes, driven by misconceptions about side effects and religious beliefs. This "knowledge-attitude gap" suggests that mere awareness is insufficient without

targeted interventions to address deeply rooted cultural and religious biases. Similarly, in Zambia, patriarchal norms often prioritize communal harmony over individual health needs, discouraging parents from advocating for contraceptives despite recognizing their benefits (Chola et al., 2023b). The strong odds ratio (AOR: 4.4) further highlights the transformative potential of supportive communication. This aligns with a study in Kenya, which found that parent-adolescent dialogue reduced early pregnancies by 32%, as open discussions demystified contraceptives and normalized SRH decision-making (Olenja et al., 2020). Conversely, the persistence of poor communication in nearly half of respondents may reflect structural inequities, such as limited access to SRH resources for parents (Chola et al., 2023b).

5.4 Implications to Midwifery Professional

5.4.1 Midwifery Practice

The prevalence of negative parental perceptions (51.5%) and attitudes (67.4%) underscores the need for midwives to adopt family-centred counselling approaches. By addressing myths (e.g., contraceptives cause promiscuity) and involving parents in SRH discussions, midwives can bridge knowledge gaps and foster acceptance of adolescent contraceptive use. For example, integrating culturally sensitive dialogue into prenatal or postnatal visits may normalize contraceptive education within family units.

5.4.2 Midwifery Administration

The moderate parental knowledge levels (43.5% average) and poor communication practices (43.1%) call for systemic changes. Midwifery leaders should advocate for policies mandating SRH education workshops for parents, leveraging community health workers or religious leaders to improve outreach. For instance, Zambia's Adolescent Health Strategy could incorporate parental engagement modules to align with national goals. The link between supportive communication and positive perceptions (AOR: 4.4) suggests administrators should fund parent-adolescent dialogue programs. Allocating resources to train midwives in conflict-resolution and intergenerational communication could reduce barriers to contraceptive access.

5.4.3 Midwifery Education

With 36.8% of parents lacking adequate contraceptive knowledge, midwifery training programs must emphasize cultural competence and communication strategies. Simulated scenarios on addressing parental resistance (e.g., religious objections) can better prepare students for real-world challenges. Given the evolving nature of SRH misinformation, continuing education on adolescent-friendly contraceptive methods (e.g., implants, emergency contraception) is critical. Workshops on Zambia's cultural norms (e.g., patriarchal decision-making) can improve midwives' ability to navigate sensitive discussions.

5.4.4 Midwifery Research

The persistent knowledge-attitude gap (e.g., 43.5% average knowledge vs. 67.4% negative attitudes) warrants longitudinal research to explore why knowledge does not always translate to acceptance. Investigating socio-economic moderators (e.g., poverty, marital status) could refine interventions.

5.5 Conclusion

The findings from this study provide valuable insights into parents' perceptions, knowledge, attitudes, and communication practices regarding adolescents' use of contraceptives in Chawama Township, Lusaka, Zambia. The study revealed that a slight majority of respondents (51.5%) hold a negative perception towards adolescents' use of contraceptives. This indicates that negative perceptions are more prevalent than positive ones, suggesting a marginally unfavourable overall perception within the study population. The study has identified several factors associated with a positive perception towards adolescents' use of contraceptives. Parents with an average to adequate level of knowledge on contraceptives were more likely to have a positive perception additionally, parents with positive attitudes towards contraceptives, and those with supportive SRH communications were more likely to have a positive perception. These findings emphasize the importance of education, positive attitudes, and effective communication in shaping favourable perceptions towards adolescent contraceptive use. Thus, the study underscores the complex interplay of perception, knowledge, attitudes, and communication in influencing parents' views on adolescents' use of contraceptives. The results suggest that interventions should focus on enhancing parents' knowledge, fostering positive

attitudes, and promoting supportive communication to improve adolescents' access to and utilization of contraceptives. By addressing these factors, stakeholders can work towards creating a more supportive environment for adolescent sexual and reproductive health in Chawama Township and beyond.

5.6 Application of the Study to the Social-Ecological Model

The findings were analysed through the lens of the social-ecological model, which considers multiple levels of influence on behaviour: On the individual level, it can be concluded that parents' knowledge and education levels significantly influenced their perceptions of adolescent contraceptive use. On the interpersonal level, social-cultural norms and family dynamics played a crucial role in shaping parents' perception towards contraception. While on the community level, community norms and support systems impacted parents' perceptions and acceptance of contraceptive use among adolescents. However, the study did not assess the societal level factors that may impact parental perception and behaviours.

5.7 Recommendations

Based on the finding of this study, the following recommendations are forwarded.

1. Health Practitioners must develop training programs to improve parental-adolescent SRH communication, leveraging the finding that supportive dialogue increases positive perceptions by 4.4 times (AOR: 4.4; $p < 0.001$). Use role-playing and culturally tailored tools to address the 43.1% with poor communication practices.
2. Policymakers must integrate parental SRH education into Zambia's National Adolescent Health Strategy, prioritizing funding for community workshops targeting the 19.7% with inadequate contraceptive knowledge. Align with goals to reduce adolescent pregnancies by 40% by 2030.
3. Health Practitioners and Policymakers should collaborate on mobile health campaigns (e.g., SMS, radio) to improve contraceptive literacy among the 36.8% with adequate knowledge, shown to boost positive perceptions (AOR: 3.9; $p = 0.001$). Highlight safety and efficacy to counter misinformation.
4. Researchers should investigate socio-cultural drivers of the 67.4% negative parental attitudes, focusing on myths (e.g., promiscuity fears) and patriarchal

norms. Partner with local leaders to design interventions replicating Kenya's success in reducing myths (Mwangi et al., 2021).

5.8 Study Limitations and Strengths

The study's sample size may limit the generalizability of the findings to other communities. Also, the reliance on self-reported data may introduce bias, as respondents might provide socially desirable answers; and the cross-sectional design of the study limited the ability to establish causal relationships between variables. However, despite these limitations, the study had some strengths. For instance, the community-based approach provided valuable insights into the perceptions of parents within the specific cultural context of Chawama Township. The study's comprehensive analysis of various factors influencing parental perceptions offered a holistic understanding of the issue, and the identification of significant associations between education, employment status, knowledge level, and parental perceptions provides a strong foundation for targeted interventions.

5.9 Utilisation and Dissemination of Findings

The findings of the study will be presented to the faculty of the School of Nursing Sciences, University of Zambia. The results will be presented to various stakeholders involved in developing health education materials and management protocols for antenatal mothers and health promotion, these includes; Lusaka District Health Office as they will provide the study site for implementation of the gaps identified in the study, Ministry of Health and its cooperating partners. In addition, bound copies of the study will be submitted to the School of Nursing Sciences, UNZA-Medical Library and Main Library. The findings will be published in a reputable peer reviewed journal like the Open Journal of Obstetrics and Gynaecology.

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APPENDICES

Appendix I: Information Sheet

Introduction

My name is Pamela Namakando. I am a Midwifery Masters Student in the School of Nursing at the University of Zambia. As partial fulfilment of the program, I am required to undertake a research in any area of benefit to the provision of quality health care and to contribute to the knowledge.

Purpose of the study

This research is based on **perceptions of parents towards the use of contraceptives by adolescents in Chawama Township – Lusaka.** This study builds on researches previously carried out by the research team and that of others and has been designed to allow comparisons with previous findings.

Description of the study

You will be asked to complete a structured questionnaire which I will personally administer over an estimated period of 30 minutes. You may also wish to agree to a follow-up interview to find out more about your thoughts. The questionnaire will ask you about your opinions and experiences regarding contraceptive care. Your views and experience are just what the study is interested in exploring. Results of the research will not be shared with the public. It will be kept in the Library at the University of Zambia. If you wish to be given a copy of any reports resulting from the research, please ask us to put you on the circulation list.

Confidentiality

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified or identifiable in any reports or publications. Any data collected about you in the questionnaire will be stored on computer in a form protected by passwords and other relevant security processes and technologies. Data collected may be shared in an anonymized form to allow reuse by Chawama level 1 hospital or University. These anonymized data will not allow any individuals or their institutions to be identified or identifiable.

Voluntary participation and withdrawal

It is up to you to decide whether or not to take part. If you do decide to take part, you will be able to keep a copy of this information sheet and you should indicate your agreement to the online consent form. You can still withdraw at any time. You do not have to give a reason.

Risks and Benefits

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will have a beneficial impact on contraceptive. Results will be shared with health workers and patients in general in order to improve their professional work and conduct respectively.

Contact persons

1. Pamela Namakando - Principal investigator, cell: +260979836435, Email: pcnamakando2004@yahoo.ca and
2. . Prof. Catherine Mubita Ngoma - PhD. **(Supervisor),** University of Zambia, School of Nursing Sciences, Contact: +…260966652879.
3. **The Chairperson, UNZABREC,** Ridgeway Campus, P.O Box 50110, Lusaka, Tel: +260977925304, E-mail: s.munsaka@unza.zm

Appendix II: Informed Consent Form

TOPIC: PERCEPTIONS OF PARENTS TOWARDS THE USE OF CONTRACEPTIVES BY ADOLESCENTS IN CHAWAMA TOWNSHIP – LUSAKA

The information about the study has been read out and explained to me. I understand that taking part in the study is voluntary and that my privacy will be respected and protected. All questions I had have been answered to my fulfilment. I choose to take part freely and voluntarily.

I ..... has given consent to take part in the study.

Signature ……..or (Thumb print).....

Date...../...../.....

Data Collector/ Interviewer's Signature

The participant has understood the purpose and content of the study and has made informed consent to participate in this study.

Name of Interviewer……

Signature……

Data……/……/……

Appendix III: Data Collection Tool

No._____

QUESTIONNAIRE

UNIVERSITY OF ZAMBIA

SCHOOL OF NURSING SCIENCES

DEPARTMENT OF MIDWIFERY, WOMEN AND CHILD HEALTH

TOPIC: RESEARCH TOPIC: PERCEPTIONS OF PARENTS TOWARDS THE USE OF CONTRACEPTIVES BY ADOLESCENTS IN CHAWAMA TOWNSHIP – LUSAKA

I am a student at University of Zambia pursuing studies in Nursing. You have been randomly picked to participate in this academic survey where we are trying to investigate perception **of parents towards the use of contraceptives among adolescents in Chawama Level I Hospital.**

Your participation is purely voluntary and therefore I seek your consent to respond to brief questions below.

Date of interview……...

Place of interview…….

Name of interviewer……

Serial number of the interviewee……...

INTRODUCTION TO THE INTERVIEWER

1. Introduce yourself to the interviewee(s)
2. Explain the purpose of the interview
3. Get verbal consent from the interviewee before conducting the interview.
4. Assure the interviewee of confidentiality and anonymity.
5. Do not write the name of the respondent on the interview schedule to ensure anonymity.

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. How old were you on your last birthday? ☐☐
2. Sex (a) Male ☐ (b) Female ☐
3. What is your marital status?
   (a) Single ☐ (c) Married ☐
   (b) Separated ☐ (d) Widowed ☐
4. What is your religious affiliation?
   (a) Pentecostal ☐
   (b) Catholic ☐
   (c) Jehovah's witness
   (d) SDA
   (e) RCZ
   (f) UCZ
   (g) Muslim
   (h) Others
   (Specify)……
   …
5. What is your highest level of education?
   (a) Primary (b)Secondary (c) Tertiary (d) None
6. What is your occupation?
   (a) Not working
   (b) Businessperson
   (c) Self employed
   (d) Formal employment
   (e) Retired
7. What is your tribe …….
8. How many children do you have? ……..

SECTION B: KNOWLEDGE ON CONTRACEPTIVES & ADOLESCENT RISK SEXUAL BEHAVIOURS

9. **Meaning of contraceptives**		**YES**	**No**	**I don't know**
a.	Method of preventing pregnancy			
b.	Method of terminating pregnancy			
c.	Methods of preventing STIs			
d.	Method of controlling family size			
e.	Method of spacing children			
f.	Methods of increasing sexual pleasure			
g.	Methods of abortion			

10. **Types of contraceptives**		**YES**	**No**	**I don't know**
a.	Condoms			
B	Diaphragm			
C	Intra uterine device			
D	Microgynon			
E	Noristaret			
F	Depo provera			
G	Withdrawal			
H	Traditional			
I	Breast feeding			
J	Sterilization			
K	Bilateral tubal ligation			
L	Implant			

11. **Benefits of contraceptives**		**YES**	**No**	**I don't know**
A	Sexual pleasure			
B	Prevention of pregnancies			
C	Prevention of STIs			
D	Prevention of abortion			

12. **Side effects of contraceptives**		**YES**	**No**	**I don't know**
A	They are harmful			
B	The cause weight gain			
C	They cause weight loss			
D	Condoms burst			
E	Heavy periods			
F	No periods			
G	Irregular periods			
H	infertility			

13. Source of knowledge of contraceptives		YES	No	I don't know
A	Clinics or hospitals			
B	TV/Radio			
C	Social media			
D	Newspapers			
E	Friends			
F	Partner			
G	Church/mosque			
H	Others			

C. ATTITUDES AND BELIEFS

14. Contraceptive Perceptions and social cultural norms	Agree	Disagree	Undecided
Parents have control on their children to use or not use contraceptives			
I think adolescents are still using contraceptives even against parental advise and knowledge?			
I am willing to allow unmarried adolescents to use contraceptives to avoid STIs and pregnancy			
As a parent you can collect contraceptives for your child from a clinic for free			
I can buy contraceptives for my child to protect her/him			
I can refer my sexually active adolescent to health facility to obtain knowledge of contraceptives?			
Will you rebuke your adolescent if you see him/her with contraceptives			

D. COMMUNICATION

15. Perceptions and communication	Agree	Disagree	Undecided
I support talking about contraceptives to my unmarried adolescent/child			
I feel free to talk about contraceptives with my unmarried adolescent/child			
Only males should use contraceptives in my own opinion			
I do not want my adolescent to use contraceptives because it encourages promiscuity			

I do not support my children's usage because it is against my culture and religion			

E. PERCEPTIONS ABOUT CONTRACEPTIVES

16. Who should use contraceptives		**YES**	**No**	**I don't know**
A	Only the married			
B	Singles only			
C	Females only			
D	Males only			
E	Both Males and females			

17. Dangers of unprotected sex among adolescents		**YES**	**No**	**I don't know**
A	Unwanted pregnancies			
B	STIs			
C	Abortions			
D	HIV/AIDS			
E	Infertility			

18. Types of contraceptives you can prefer your adolescent child to use		**Agree**	**Disagree**	**Undecided**
A	Condoms			
B	Diaphragm			
C	Intra uterine device			
D	Microgynon			
E	Noristaret			
F	Depo provera			
G	Withdrawal			
H	Traditional			
I	Breast feeding			
J	Sterilization			
K	Bilateral tubal ligation			
L	Implant			
m	Jadelle			

END OF QUESTIONNAIRE, THANK FOR PARTICIPATING

Appendix IV: Ethical Approval Letter

UNIVERSITY OF ZAMBIA
BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: +260 977925304
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753

Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia
E-mail: unzarec@unza.zm

Federal Assurance No. FWA00000338 IRB00001131 of IORG0000774 NHRAR-REC No 2021-05-0002

30th October 2024

Your REF. No. 5444-2024.

Ms. Pamela Namakando,
University of Zambia,
School of Nursing Sciences,
P.O Box 50110,
Lusaka.

Dear Madam,

RE: PERCEPTIONS OF PARENTS TOWARDS THE USE OF CONTRACEPTIVES BY ADOLESCENTS IN CHAWAMA TOWNSHIP – A COMMUNITY BASED SURVEY (REF. NO. 5444-2024)

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee on 30th October, 2024. The proposal is **approved**. The approval is based on the following documents that were submitted for review:

a) **Study proposal**
b) **Questionnaires**
c) **Participant Consent Form**

APPROVAL NUMBER : REF. No. 5444-2024.

This number should be used on all correspondence, consent forms and documents as appropriate.

i. **APPROVAL DATE : 30th October 2024**
ii. **TYPE OF APPROVAL : Standard**
iii. **EXPIRATION DATE OF APPROVAL : 29th October 2025**
iv. After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the UNZABREC Offices should be submitted one month before the expiration date for continuing review.
v. **SERIOUS ADVERSE EVENT REPORTING**: All SAEs and any other serious challenges/problems having to do with participant welfare, participant safety and study integrity must be reported to UNZABREC within 3 working days using standard forms obtainable from UNZABREC.
vi. **MODIFICATIONS**: Prior UNZABREC approval using standard forms obtainable from the UNZABREC Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
vii. **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the UNZABREC using standard forms obtainable from the UNZABREC Offices.
viii. **NHRA:** You are advised to obtain final study clearance and approval to conduct research in Zambia from the National Health Research Authority (NHRA) before commencing the research project.
ix. **QUESTIONS**: Please contact the UNZABREC on Telephone No. +260977925304 or by e-mail on unzarec@unza.zm.
x. **OTHER**: Please be reminded to send in copies of your research findings/results for our records. You are also required to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study. Use the online portal: unza.rhinno.net for further submissions.

Yours sincerely,

Munsaka.

Prof. Sody Mweetwa Munsaka, BSc., MSc., PhD
CHAIRPERSON
Tel: +260977925304
E-mail: s.munsaka@unza.zm

Appendix V: Research Authorisation Letter (NHRA)

NATIONAL HEALTH RESEARCH AUTHORITY

Lot No. 18961/M, off Kasama Road, Chalala, P.O. Box 30075, LUSAKA
Tell: +260211 250309 | Email: znhrasec@nhra.org.zm | www.nhra.org.zm

NHRA-1685/06/11/2024 **8th November 2024**

The Principal Investigator,
Ms. Pamela Namakando,
University of Zambia, School of Nursing Sciences, P.O Box 50110, Lusaka.,

Dear Ms. Pamela Namakando,

Re: Request for Authority to Conduct Research

The National Health Research Authority Is in Receipt of Your Request for Authority to Conduct Research Titled **"PERCEPTIONS OF PARENTS TOWARDS THE USE OF CONTRACEPTIVES BY ADOLESCENTS IN CHAWAMA TOWNSHIP – A COMMUNITY BASED SURVEY"**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been **approved** on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised.
2. Progress updates are provided to NHRA bi-annually from the date of commencement of the study.
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country.
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, University leadership, and all key respondents.

Yours sincerely,

National Health Research Authority

Prof Victor Chalwe,
Acting Director/Chief Executive Officer

School of Nursing Sciences

P.O. Box RW 50110

Lusaka

5th May 2025

The Assistant Dean Postgraduate

IDE

University of Zambia

Lusaka

RE: Dissertation corrections following Examination by Pamela Namakando

I write to confirm that the above mentioned MSc in Midwifery and women's health student has done correction as pointed out by examiners. Her research topic is "Perceptions of parents towards the use of contraceptives by adolescents in Chawama township – A community based survey". She may proceed and bind the dissertation in readiness for submission.

Your Assistance will be highly appreciated

Prof C Ngoma

Research Supervisor