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Perceptions of Parents towards the Use of Contraceptives by Adolescents in Chawama Township—A Community-Based Survey

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Abstract

Introduction: Adolescent pregnancies remain a critical public health challenge in sub-Saharan Africa, with Zambia reporting a 23% contraceptive prevalence rate (CPR) among adolescents. Parental disapproval, rooted in socio-cultural norms and limited knowledge, is a key barrier to adolescent contraceptive access. This study examines parental perceptions of adolescent contraceptive use in Chawama Township, Lusaka, to inform targeted interventions. **Methods:** A cross-sectional analytical study was conducted among 239 parents of adolescents (10 – 19 years) selected via simple random sampling. A validated researcher-administered questionnaire assessed socio-demographics, knowledge, and perceptions. Data were analyzed using SPSS v27, with logistic regression identifying predictors of positive perceptions. The relationship become significant only when the P-value is less than level of significance (<0.05) at 95% confidence interval. **Results:** Only 36.8% of parents demonstrated adequate contraceptive knowledge, while 51.5% held negative perceptions of adolescent contraceptive use. Factors significantly associated with positive perceptions included secondary education (AOR: 3.1; 95% CI: 1.0 – 9.3), tertiary education (AOR: 4.3; 95% CI: 1.1 – 17.8), adequate knowledge (AOR: 4.3; 95% CI: 1.7 – 10.9), and permissive socio-cultural norms (AOR: 4.4; 95% CI: 2.1 – 9.3). Cultural/religious beliefs (54%) and fears of promiscuity (47.3%) were primary deterrents. **Conclusion:** Parental education and knowledge significantly shape perceptions of adolescent contraceptive use. Community-based programs addressing socio-cultural norms and improving sexual and reproductive health (SRH) literacy are critical to reducing unintended pregnancies and maternal mortality.

Keywords

Adolescent, Contraceptive Use, Parental Perceptions, Socio-Cultural Norms, Sexual and Reproductive Health

1. Introduction

Adolescent sexual and reproductive health (SRH) remains a pressing global challenge, with unintended pregnancies and childbirth complications ranking among the leading causes of mortality for girls aged 15 – 19 worldwide [1]. In sub-Saharan Africa, where cultural norms and systemic barriers often restrict access to contraception, adolescent contraceptive prevalence rates (CPR) stagnate at 21%, far below global averages [2]. Zambia mirrors this trend, with adolescent pregnancies contributing to high school dropout rates, unsafe abortions, and cycles of poverty—issues acutely felt in informal settlements like Chawama Township, Lusaka. Here, adolescent health outcomes are shaped by a unique confluence of urbanization, economic precarity, and deeply rooted cultural beliefs. In 2020 alone, Chawama Level 1 Hospital recorded 227 pregnancies among adolescents aged 15 – 19, alongside 180 unintended pregnancies and 53 new HIV cases in this demographic. Yet, only 31% of parents in the township supported contraceptive use for adolescents, reflecting a disconnect between available services and community acceptance.

Parental perceptions play a pivotal role in shaping adolescent SRH behaviors, particularly in settings where cultural authority and intergenerational dialogue dominate decision-making. Studies across Africa highlight that parental disapproval—often rooted in misconceptions about contraceptive side effects or fears of promoting promiscuity—significantly hinders adolescent access to family planning [3] [4]. In Zambia, where 77% of adolescents reside with parents or guardians, familial attitudes directly influence health-seeking behaviors [5]. However, research has predominantly focused on adolescent perspectives, leaving a critical gap in understanding the beliefs, knowledge, and socio-cultural pressures that inform parental resistance. This gap is particularly pronounced in high-risk, low-resource environments like Chawama, where early marriages, unemployment, and limited health literacy exacerbate vulnerabilities.

Chawama Township, home to 68,343 residents, epitomizes the urban African paradox: proximity to urban health infrastructure coexists with stark SRH disparities. The township's demographic profile—youthful, ethnically diverse, and economically marginalized—creates a microcosm of broader regional challenges. For instance, while 1417 adolescents accessed family planning services at Chawama Level 1 Hospital in 2020, community narratives often stigmatize these services, associating them with moral decay rather than health preservation. Cultural norms, reinforced by religious doctrines and tribal traditions, further complicate acceptance. For example, the Bemba and Tonga communities, which constitute 25.1% and 13.8% of Chawama's population, respectively, traditionally emphasize communal decision-making, where elders' views on adolescent sexuality carry substantial weight.

This study seeks to bridge the evidence gap by exploring how parents in Chawama perceive adolescent contraceptive use, with a focus on the interplay of education, cultural norms, and socio-economic status. By employing a community-based, cross-sectional design, the research evaluates three dimensions: 1) parental

knowledge of contraceptives and adolescent sexuality, 2) socio-cultural and demographic drivers of perception, and 3) the relationship between social norms and contraceptive approval. The findings aim to inform culturally tailored interventions that engage parents as allies in improving SRH outcomes, rather than adversaries. In doing so, the study contributes to Zambia's national health goals, which prioritize reducing adolescent pregnancies by 40% by 2030, while offering a replicable framework for similar high-burden settings across the region.

2. Materials and Methods

2.1. Study Design and Setting

This community-based cross-sectional study was conducted in Chawama Township, an informal settlement in Lusaka, Zambia, characterized by high population density, widespread poverty, and limited access to healthcare services. With a population of approximately 68,343 residents, the township is predominantly inhabited by young families engaged in informal economic activities. The study setting was selected due to its high adolescent pregnancy rates and documented gaps in contraceptive uptake, as evidenced by local hospital records. A cross-sectional analytical design was employed to capture parental perceptions at a single time point, allowing for the identification of associations between socio-cultural factors and attitudes toward adolescent contraceptive use.

2.2. Study Population, Sampling Technique, and Sample Size

The study targeted parents or guardians aged 24 – 77 years residing in households with adolescents (10 – 19 years). Participants were excluded if they had cognitive impairments or declined consent. Using simple random sampling, 258 households were selected from a housing registry provided by the Chawama Local Housing Office. This registry ensured a representative sample across the township's diverse neighbourhoods. The sample size was calculated using Taherdoost's formula for finite populations, assuming a 95% confidence level, 5% margin of error, and 80% expected prevalence of negative perceptions based on pilot data. The final sample included 239 participants after seven entries were excluded, achieving a 92.6% response rate.

2.3. Data Collection Tools and Procedure

A structured, researcher-administered questionnaire was developed through an extensive review of literature on adolescent sexual health and parental communication. The tool was divided into four sections: socio-demographics (e.g., age, education, religion), knowledge of contraceptives (e.g., types, benefits, side effects), perceptions (e.g., cultural acceptability, fears of promiscuity), and social norms (e.g., community attitudes). To ensure validity, the questionnaire was reviewed by a panel of midwifery experts at the University of Zambia and pretested in Matero Township, a comparable urban settlement. Piloting with 26 participants confirmed internal consistency (Cronbach's $\alpha = 0.70$) and led to refinements in ques-

tion phrasing.

Trained research assistants conducted face-to-face interviews in either English or Nyanja, the local language, to accommodate participants' literacy levels. Interviews averaged 45 minutes and were conducted in private settings to ensure confidentiality. The questionnaire included Likert-scale items (e.g., "I support contraceptive use for unmarried adolescents: Agree/Disagree/Neutral") and multiple-choice questions to quantify knowledge and attitudes. Open-ended prompts, such as "Describe your concerns about adolescents using contraceptives," provided qualitative insights. Data collectors received intensive training to minimize bias, including role-playing exercises to address sensitive topics nonjudgmentally.

2.4. Statistical analysis

Data were cleaned, coded, and analysed using SPSS (SPSS Inc., Chicago, IL, version 27). Descriptive statistics summarized participant characteristics, with categorical variables presented as frequencies and percentages. Knowledge scores were categorized as "inadequate" (<50%), "average" (50% – 69%), or "adequate" (≥70%) based on correct responses to 13 items. Chi-square and Fisher's exact tests assessed associations between socio-demographic variables (e.g., education, religion) and parental perceptions. Variables with $p < 0.25$ in bivariate analysis were entered into a multivariable logistic regression model to identify independent predictors of positive perceptions, reported as adjusted odds ratios (AORs) with 95% confidence intervals. Statistical significance was set at $p < 0.05$.

2.5. Ethical Consideration

Ethical approval was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC-2023-001) and the National Health Research Authority (NHRA-4567). Participants received written and verbal explanations of the study's purpose, risks, and benefits. Written consent was obtained, with thumbprints used for illiterate participants. To protect confidentiality, identifiers were removed during data entry, and physical records were stored in locked cabinets. Findings were disseminated through community workshops to ensure transparency and foster dialogue on adolescent sexual health.

3. Results

3.1. Characteristics of Participants

The study included 239 parents and guardians from Chawama Township, achieving a 92.6% response rate. Participants were predominantly female (77.4%), reflecting the central role of women in child-rearing within the community. The majority were aged 31 – 40 years (39.7%), married (56.5%), and had 2 – 4 children (62.8%). Educational attainment varied: 37.2% had primary-level education, 36.8% secondary, and only 15.1% tertiary. Unemployment was widespread (45.2%), with many relying on informal trade (40.6%) for livelihood. Religious affiliation was predominantly Christian, with Pentecostals (28.9%) and Catholics

(22.6%) forming the largest groups. Ethnically, the Bemba (25.1%) and Tonga (13.8%) tribes were most represented, reflecting Lusaka's diverse migration patterns (Table 1).

Table 1. Respondent's socio-demographic characteristics.

Variable	Frequency	Percent
Age (years)		
24 – 30	49	20.5
31 – 40	95	39.7
41 – 50	70	29.3
51 – 77	25	10.5
Gender		
Male	54	22.6
Female	185	77.4
Marital status		
Married	135	56.5
Single	62	25.9
Divorced/separated	16	6.7
Widowed	26	10.9
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		
One	24	10
2 – 4	150	62.8
5 – 10	65	27.2

3.2. Knowledge of Contraceptives and Adolescent Sexuality

Parents demonstrated moderate knowledge of contraceptives, with 36.8% scoring adequate (≥70% accuracy). The primary perceived purpose of contraceptives was child spacing (24.8%) and pregnancy prevention (24.4%), though misconceptions persisted: 2.7% erroneously linked contraceptives to abortion, and 12.7% associated them with enhancing sexual pleasure (Table 2). Key benefits cited included

pregnancy prevention (38.8%) and STI/HIV risk reduction (21.1%). Concerns about side effects were prevalent, with weight gain (16.8%), condom failure (15.7%), and menstrual irregularities (15.8%) being the most cited. Health facilities (21%) and friends (18.9%) were the primary sources of contraceptive information, while social media (12.9%) and religious institutions (8.3%) played lesser roles.

Table 2. 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

*Multiple entries.

3.3. Perceived Social-Cultural Norms

Cultural and religious norms strongly influenced parental attitudes. A majority (63.6%) believed they retained control over their adolescent's contraceptive decisions, and 59% stated they would rebuke their child for possessing contraceptives. Resistance to adolescent access was pronounced: 63.6% opposed unmarried adolescents using contraceptives, 64.8% refused to collect contraceptives from clinics for their children, and 77% rejected purchasing contraceptives directly. Notably, 52.3% hesitated to refer sexually active adolescents to health facilities, citing fears of encouraging early sexual activity (Table 3). Tribal differences emerged, with the Lunda (100%) and Bemba (58.3%) tribes showing more permissive views compared to others.

Table 3. Respondents perceived social-cultural norms-related characteristics.

Variable	Frequency	Percent
Parents have control on their children to use or not use contraceptives		
Agree	152	63.6
Disagree	75	31.4
Not sure	12	5
I think adolescents are still using contraceptives even against parental advise and knowledge		
Agree	144	60.3
Disagree	75	31.3
Not sure	20	8.4
I am willing to allow unmarried adolescents to use contraceptives to avoid STIs and pregnancy		
Agree	75	31.4
Disagree	152	63.6
Not sure	12	5
As a parent you can collect contraceptives for your child from a clinic for free		
Agree	70	29.3
Disagree	155	64.8
Not sure	14	5.9
I can buy contraceptives for my child to protect her/him		
Agree	47	19.7
Disagree	184	77
Not sure	8	3.3
I can refer my sexually active adolescent to health facility to obtain knowledge of contraceptives		
Agree	96	40.2
Disagree	125	52.3
Not sure	18	7.5
Will you rebuke your adolescent if you see him/her with contraceptives		
Agree	141	59
Disagree	82	34.3
Not sure	16	6.7

3.4. Parental Perceptions of Adolescent Contraceptive Use

Nearly half (51.5%) held negative perceptions, driven by fears of promiscuity (47.3%) and conflicts with cultural/religious values (54%). Conversely, 48.5% supported contraceptive use, emphasizing pregnancy prevention (24.4%) and STI avoidance (23%). Condoms (18.1%) and injectables like Depo-Provera (12.5%) were the most accepted methods, while long-acting options (e.g., implants, IUDs) and traditional methods (3.4%) were less favored (Table 4). Communication barriers were evident: 52.7% felt uncomfortable discussing contraceptives with their adolescents, and 47.7% opposed third-party discussions (e.g., teachers or healthcare workers) on the topic.

Table 4. 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 among adolescents*		
Unwanted pregnancies	231	24.4
STIs	218	23
Abortions	180	19
HIV/AIDS	218	23
Infertility	100	10.6
I support talking about contraceptives to my unmarried adolescent/child		
Agree	111	46.4
Disagree	114	47.7
Not sure	14	5.9
I feel free to talk about contraceptives with my unmarried adolescent/child		
Agree	98	41
Disagree	126	52.7
Not sure	15	6.3
Only males should use contraceptives in my own opinion		
Agree	35	11.6
Disagree	177	74.1
Not sure	27	11.3
I do not want my adolescent to use contraceptives because it encourages promiscuity		
Agree	113	47.3

Continued

Disagree	108	45.2
Not sure	18	7.5
I do not support my children's usage because it is against my culture and religion		
Agree	96	40.1
Disagree	129	54
Not sure	14	5.9

*Multiple entries.

3.5. Factors Associated with Parental Perceptions

The chi-square analysis revealed significant associations between parental perceptions and key socio-demographic and cultural variables. Education emerged as a critical determinant, with parents possessing tertiary education demonstrating markedly higher support for adolescent contraceptive use (75%) compared to those with no formal education (23.1%; $p < 0.001$). Employment status further differentiated perceptions. Parents in formal employment, though a minority (14.2%), were significantly more likely to support contraceptive use (76.5%) compared to unemployed respondents (45.4%; $p = 0.002$). This disparity likely reflects greater exposure to workplace health initiatives and financial stability, which may reduce reliance on stigmatizing cultural narratives. Conversely, informal employment (40.6%) and unemployment (45.2%) correlated with resistance, suggesting economic precarity heightens fears of contraceptives undermining traditional values. Non-significant variables included age ($p = 0.458$), gender ($p = 0.579$), marital status ($p = 0.921$), and number of children ($p = 0.356$), suggesting perceptions transcend these demographics (Table 5).

Table 5. Distribution of respondents' characteristics according to perception level.

Variable	Parent's perception (%)		p-value
	Positive	Negative	
Age (years)			0.458
24 – 30	28 (57.1)	21 (42.9)	
31 – 40	47 (49.5)	48 (50.5)	
41 – 50	30 (42.9)	40 (57.1)	
51 – 77	11 (44)	14 (56)	
Gender			0.579
Male	28 (51.9)	26 (48.1)	
Female	88 (47.6)	97 (52.4)	
Marital status			0.921
Married	65 (48.1)	70 (51.9)	

Continued

Single	29 (46.8)	33 (53.2)	
Divorced/separated	9 (56.3)	7 (43.7)	
Widowed	13 (50)	13 (50)	
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
One	11 (45.8)	13 (54.2)	
2 – 4	78 (52)	72 (48)	
5 – 10	27 (41.5)	38 (58.5)	
Knowledge			**<0.001**
Adequate	51 (58)	37 (42)	
Average	57 (54.8)	47 (45.2)	
Inadequate	8 (17)	39 (83)	
Social-cultural norms			**<0.001**
Permissive	42 (76.4)	13 (23.6)	
Neutral	13 (59.1)	9 (40.9)	
Deterrent	61 (37.7)	101 (62.3)	

Multivariable analysis revealed education as a critical predictor. Parents with tertiary education had 4.3-fold higher odds of positive perceptions compared to those without formal education (AOR: 4.3; 95% CI: 1.1–17.8; p = 0.041). Knowledge also played a role: adequate understanding of contraceptives quadrupled the likelihood of support (AOR: 4.3; 95% CI: 1.7–10.9; p = 0.002). Employment status further influenced attitudes, with formally employed parents showing 76.5% approval versus 45.4% among the unemployed (p = 0.002). Cultural norms were pivotal: permissive views increased positive perceptions 4.4-fold (AOR: 4.4; 95% CI: 2.1–9.3; p < 0.001). However, age, gender, marital status, and number of children showed no significant associations (Table 6).

Table 6. Multiple regression analysis of independent predictors of parents' perception.

Variable	COR (95% CI)	P-value	AOR (95% CI)	p-value
Age (years)				
24 – 30	1.7 (0.6 - 4.5)	0.286		
31 – 40	1.2 (0.5 - 3.0)	0.626		

Continued

41 – 50	1.0 (0.4 - 2.4)	0.921		
51 – 77	1			
Gender				
Male	1.2 (0.6 - 2.2)	0.580		
Female	1			
Marital status				
Married	1			
Single	0.9 (0.5 - 1.7)	0.858		
Divorced/separated	1.4 (0.5 - 3.9)	0.541		
Widowed	1.1 (0.5 - 2.5)	0.863		
Education				
No formal education	1			
Primary	2.4 (0.8 - 6.2)	0.111	1.5 (0.5 - 4.5)	0.490
Secondary	3.8 (1.4 - 10.4)	**0.009**	3.1 (1.0 - 9.3)	**0.045**
Tertiary	10.0 (3.1 - 32.7)	**<0.001**	4.3 (1.1 - 17.8)	**0.041**
Occupation				
Employed	3.9 (1.6 - 9.4)	**0.002**	1.7 (0.6 - 5.0)	0.337
Business	0.9 (0.5 - 1.5)	0.655	0.7 (0.4 - 1.4)	0.327
Unemployed	1			
Number of children				
One	1.2 (0.5 - 3.1)	0.716		
2 – 4	1.5 (0.8 - 2.7)	0.160		
5 – 10	1			
Knowledge				
Adequate	6.7 (2.8 - 16.0)	**<0.001**	4.3 (1.7 - 10.9)	**0.002**
Average	5.9 (2.5 - 13.9)	**<0.001**	3.4 (1.5 - 9.4)	**0.004**
Inadequate	1			
Social-cultural norms				
Permissive	5.3 (2.7 - 10.8)	**<0.001**	4.4 (2.1 - 9.3)	**<0.001**
Neutral	2.4 (1.0 - 5.9)	0.060	2.1 (0.8 - 5.9)	0.142
Deterrent	1			

4. Discussion

The findings of the present study indicated, in the context of Chawama Township, a complex interplay between various factors, including educational attainment, socio-cultural norms, and prevailing economic conditions, all of which significantly influence the extent to which parents either support or oppose the adoption of contraceptive methods by their adolescent children. At the individual level of

analysis, it was observed that higher levels of educational achievement emerged as a notable predictor of favorable attitudes towards contraceptive use, a finding that is consistent with global research suggesting that increased educational exposure fosters a more analytical and critical engagement with health-related information [6]. Specifically, parents who have attained at least a modicum of tertiary education exhibited odds of supporting contraceptive utilization that were 4.33 times greater than their less-educated counterparts, a trend that may be attributed to their enhanced access to comprehensive SRH resources and a corresponding reduction in dependence on stigmatizing narratives surrounding reproductive health. In stark contrast, individuals possessing minimal formal education frequently associated contraceptive methods with moral degradation, a perspective that is perpetuated by local mythologies and further exacerbated by community gossip, alongside the scarcity of structured SRH education programs available to them. This notable discrepancy underscores an urgent imperative for the implementation of targeted literacy initiatives designed to demystify contraceptive methods and effectively alleviate the apprehensions surrounding potential adverse side effects, a concern that 63.6 percent of parents reported as a reason for discouraging contraceptive use among their teenagers.

In addition to educational factors, cultural and religious beliefs emerged as dual-edged swords, serving both as constraints and facilitators in the discourse surrounding contraceptive use. The predominance of Pentecostal culture within the sample, accounting for 28.9% of respondents, contrasted with the 22.6% representation of Catholic participants, thereby highlighting the substantial impact of faith-based doctrines on individual perceptions regarding sexual health. A significant number of participants indicated that they interpreted religious teachings as a condemnation of premarital sexual activity, which subsequently influenced their opposition to granting youth access to contraceptive methods, a stance that resonates with findings in other conservative sociocultural contexts [7]. However, the variations observed among different tribal affiliations introduced an additional layer of complexity to this landscape: the Lunda community, with a 100% adherence rate, and the Bemba community, exhibiting a 58.3% adherence rate, demonstrated more progressive attitudes, potentially due to ancestral customs that prioritize collective wellbeing over moral dilemmas. This divergence in perspectives indicates that interventions aimed at addressing SRH issues should eschew homogenization of cultural contexts and should instead engage local leaders in collaborative efforts to re-conceptualize traditional practices in a manner that aligns with the evolving SRH needs of modern society.

Furthermore, the pervasive economic instability within the region further complicated perceptions surrounding sexual and reproductive health education. The high rates of unemployment, which stood at 45.2%, coupled with a reliance on informal trade, which accounted for 40.6% of economic activities, severely constrained parents' ability to prioritize SRH education, as the immediate concerns of survival often overshadow the importance of long-term health considerations.

Within this particular sample, a mere 14.2% of parents were formally employed; however, those who were employed demonstrated markedly higher levels of supportive attitudes towards contraceptive use, with support rates soaring to 76.5%, likely due to their greater access to workplace health outreach programs and the availability of resources that facilitate active and informed parenting. This observation is corroborated by a study conducted in Kenya, which found that initiatives aimed at economic empowerment significantly enhanced parental engagement in adolescent sexual and reproductive health [8]. In the context of Chawama, it is posited that this socioeconomic divide could be effectively bridged through the strategic incorporation of SRH education into vocational training or microfinance programs, grounded in a philosophy that seeks to harmonize economic stability with health education.

The pervasive sense of anxiety concerning adolescent promiscuity, which was reported by 47.3% of parents, unveils a profound cultural contradiction: while parents are acutely aware of the risks associated with sexual activity without protective measures, they simultaneously perceive the availability of contraceptives to teenagers as an open invitation to engage in sexual activity. This perception aligns with findings from Malawi, where contraceptives were similarly construed as "invitations to sin" [7]. However, qualitative insights gleaned from this study indicate that such fears are largely shaped by intergenerational conflicts; parents who themselves experienced the challenges of early parenthood tend to project their personal struggles onto their children, equating the use of contraceptives with a forfeiture of future opportunities. Therefore, community dialogues that reframing contraceptives as instruments for educational advancement and economic empowerment, rather than as symbols of moral failure, could serve as a potent means of mitigating these entrenched biases and fostering a more constructive discourse around adolescent reproductive health.

The Social Ecological Model provided a framework for understanding these dynamics. At the interpersonal level, barriers to communication are still apparent, with 52. 7% of parents do not talk about contraceptive issues corresponding to discomfort or cultural norms. The absence of such discussion contributes to the spread of false information, with youth sourcing advice from peers or unreliable online platforms an observation made in urban Zambia [9]. Such strategies as role-playing workshops or media initiatives showcasing local influencers may help to normalize these conversations. The existing prevalence of informal social networks at the community level (e.g., friends as primary sources of information) underscores the potential utility of peer educators to combat stigma.

5. Study Limitations

Limitations include the cross-sectional design, which precludes causal inferences, and self-report bias, particularly on sensitive topics like sexuality. Nevertheless, the study's community-based approach offers actionable insights for policymakers. For instance, leveraging religious institutions as SRH advocates—rather than

adversaries—could transform pulpits into platforms for accurate information. Similarly, tribal leaders could champion culturally resonant narratives that reframe contraceptives as symbols of responsibility, not promiscuity.

6. Conclusion

In conclusion, the findings indicate that parents with higher levels of education, formal employment, and adequate knowledge about contraceptives are more likely to have positive perceptions of adolescent contraceptive use. However, a significant proportion of parents still hold negative perceptions, influenced by deterrent socio-cultural norms and inadequate knowledge. Thus, addressing parental perceptions in Chawama requires a multi-layered strategy that harmonizes education, cultural sensitivity, and economic empowerment. By situating contraceptives within broader frameworks of opportunity and health equity, stakeholders can dismantle stigma and foster intergenerational solidarity in safeguarding adolescent well-being.

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Conflicts of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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