

SCHOOL OF POSTGRADUATE STUDIES

**INVESTIGATING THE SOCIO-CULTURAL AND ECONOMIC FACTORS
INFLUENCING ADOLESCENT PREGNANCY IN KAFUE, ZAMBIA: A CASE OF
ZAMBIA COMPOUND (ZC)**

BY

ANNIE SAMARA BANDA

MDS23222863

A dissertation submitted in partial fulfilment for the requirement of the award of a Master's
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DECLARATION

I ANNIE SAMARA BANDA, hereby declare that this dissertation represents my own work and has not been previously submitted for a degree at the University of Lusaka or any other university. All sources I have used or quoted have been indicated and acknowledged by complete references.

Signed: _____  _____ Date: _____ 14/01/2025 _____

Supervisor: _____  _____ Date: _____ 14/01/2025 _____

Dr. C. Chagwiza

DEDICATION

This work is dedicated to all adolescent girls in Zambia Compound, whose experiences and challenges have inspired this research. Your resilience and strength are a testament to the need for continued efforts to improve the socio-cultural and economic conditions that impact your lives. A special dedication to my father, Hyden Banda, who instilled in me the value of education and perseverance. Your unwavering support and encouragement have been my foundation.

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LIST OF ABBREVIATIONS

CDC	Centre for Disease Control and Prevention
CSO	Central Statistical Office
DHS	Demographic and Health Survey
HIV	Human Immunodeficiency Virus
KMO	Kaiser-Meyer-Olkin
NGO	Non-Governmental Organization
SEM	Social Ecological Model
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

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ABSTRACT

This study investigated the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue, where high rates persist despite various intervention efforts. The study aimed to examine cultural norms' influence on adolescent sexual behaviour, assess economic conditions' effect on pregnancy rates, evaluate peer pressure's role, and analyse healthcare service accessibility. Employing a mixed-methods approach, the study used questionnaires with 344 adolescents and conducted interviews with parents/guardians, community leaders, and healthcare providers. Descriptive statistics, correlation, and regression analyses were utilized alongside thematic analysis of qualitative data. Findings revealed significant correlations between cultural norms and adolescent pregnancy ($r = .524$, $p < .01$), with traditional practices particularly influential (mean=3.05, SD=1.436). Economic factors strongly predicted pregnancy risk ($\beta = .342$, $p < .001$), while poverty increased vulnerability (mean=2.99, SD=1.402). Peer pressure significantly affected sexual behaviour ($r = .463$, $p < .01$), especially through social media (mean=3.02, SD=1.419). Healthcare accessibility showed negative correlation with pregnancy rates ($r = -.442$, $p < .01$), with privacy concerns (mean=2.92, SD=1.484) hindering utilization. Parents reported cultural taboos preventing open discussion of sexuality and fear of community judgment. Community leaders highlighted how poverty forces transactional relationships and early marriages. Healthcare providers identified inadequate privacy, limited operating hours, and insufficient youth-friendly spaces as key service delivery challenges. The study recommends developing culturally sensitive reproductive health programs, implementing youth economic empowerment initiatives, establishing comprehensive peer education programs, and creating youth-friendly healthcare spaces ensuring privacy and confidentiality.

Keywords: *cultural norms, adolescent sexual behaviour, assess economic conditions, pregnancy rates, peer pressure, and healthcare service accessibility and utilisation*

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This study investigated the socio-cultural and economic factors influencing adolescent pregnancy in Kafue, Zambia, with a specific focus on Zambia Compound (ZC). Adolescent pregnancy remained a significant public health and social issue in Zambia, with complex underlying causes. The research aimed to examine the interplay of cultural norms, social practices, and economic conditions contributing to high rates of teenage pregnancy in this urban community. By exploring these factors, the study sought to inform more effective interventions and policies to address this challenge.

1.1 Background of the Study

Adolescent pregnancy remains a significant public health and development challenge in Zambia, particularly in urban settlements like Zambia Compound in Kafue District. According to the Zambia Demographic and Health Survey (ZDHS, 2022), the national adolescent pregnancy rate stands at 29%, with Zambia Compound reporting an alarming 38% - significantly higher than the national average. This urban settlement presents a compelling case study due to its unique demographic and socioeconomic characteristics that contribute to elevated adolescent pregnancy rates. The compound's location approximately 45 kilometres south of Lusaka, combined with its semi-formal settlement status, creates a distinctive environment where traditional and modern influences converge to shape adolescent reproductive health outcomes.

Zambia Compound is characterized by high population density, limited infrastructure, and substantial economic challenges. With an estimated population of 50,000 residents, approximately 20% are adolescents aged 15-19 years (Central Statistical Office, 2020). The area has experienced rapid urbanization without corresponding development in healthcare facilities, educational institutions, or economic opportunities. Unemployment rates in Zambia Compound stand at 64%, compared to the national urban average of 41%, creating economic pressures that directly impact adolescent reproductive health decisions (Lusaka District Health Office, 2023). The collapse of local industries, particularly the Nitrogen Chemicals of Zambia factory which previously employed many residents, has worsened economic vulnerability in the community, forcing households to adopt various coping strategies that sometimes increase adolescent pregnancy risks.

The interplay of socio-cultural norms and economic factors in Zambia Compound creates a unique environment influencing adolescent pregnancy. Traditional practices, including initiation ceremonies that transition girls from childhood to adulthood, remain prevalent in this urban setting despite urbanization. A recent community assessment revealed that 72% of families in Zambia Compound maintain traditional beliefs about fertility and marriage that sometimes conflict with modern reproductive health approaches (Kafue District Development Report, 2023). The community's diverse ethnic composition brings together various cultural traditions regarding adolescent sexuality, with some emphasizing early marriage while others focus on proving fertility before marriage. Simultaneously, economic vulnerability drives transactional sexual relationships, with a local survey indicating that 45% of adolescent pregnancies in the area involved relationships with older, economically stable partners (Mwanza et al., 2022).

Healthcare access in Zambia Compound presents significant challenges. The area is served by only one public health facility with limited youth-friendly services, requiring many adolescents to travel over 5 kilometers to access reproductive health care. Utilization data from the Kafue District Health Office (2023) reveals that only 23% of sexually active adolescents in Zambia Compound access contraceptive services, compared to 37% in similar urban settlements with better healthcare infrastructure. The facility's operating hours often conflict with school schedules, while cultural stigma surrounding adolescent sexuality creates additional barriers to service utilization. Community health workers report that adolescents often avoid the local clinic due to privacy concerns and fear of judgment from healthcare providers who may know their families, forcing them to either forgo services entirely or seek care in more distant facilities at considerable expense and inconvenience.

Educational factors also play a major role in the high adolescent pregnancy rates. School completion rates for girls in Zambia Compound stand at 43%, significantly lower than the national urban average of 62% (Ministry of Education, 2023). This educational disadvantage correlates strongly with early pregnancy, as demonstrated by comparative studies showing that adolescents with secondary education are 65% less likely to experience early pregnancy than those with only primary education (Chola et al., 2023). The two secondary schools serving the compound are located at its periphery, requiring long walking distances that increase safety concerns for female students. Additionally, school-based comprehensive sexuality education implementation remains inconsistent, with teacher surveys indicating discomfort discussing reproductive health topics due

to cultural sensitivities and community expectations. The combined effect of limited educational access and inadequate sexual health information creates a significant vulnerability factor for adolescents in the area.

Previous research on adolescent pregnancy in Zambia has primarily focused on rural settings or general urban classifications without examining the specific conditions of densely populated urban settlements like Zambia Compound. Studies by Mumba et al. (2020) and Zulu et al. (2019) provided valuable information about urban adolescent pregnancy but did not explore the unique situation of settlements with mixed rural-urban cultural characteristics combined with significant economic challenges. This research gap limits the effectiveness of intervention programs, as they fail to address the specific ways socio-cultural and economic factors interact in these distinctive urban environments. Nationwide programs often apply standardized approaches that fail to account for the interplay of traditional practices, economic pressures, and limited service access that characterizes places like Zambia Compound, resulting in continued high adolescent pregnancy rates despite intervention efforts.

The effects of adolescent pregnancy in Zambia Compound extend beyond immediate health concerns to long-term development issues. Early pregnancy often leads to school dropout, with data from Kafue District Education Board showing that 82% of pregnant adolescents in Zambia Compound fail to return to school after childbirth (Kafue District Education Board, 2023). This educational disruption perpetuates cycles of poverty and limited economic opportunities. Furthermore, adolescent mothers in the area face higher rates of pregnancy complications, with district health records indicating a 43% higher incidence of obstetric complications among mothers under 18 compared to those over 20 years (Kafue District Health Office, 2023). The economic burden of caring for children limits young mothers' ability to pursue further education or vocational training, creating intergenerational patterns of poverty. Community leaders also report increased social isolation for adolescent mothers, who often face stigma and reduced social support, further compromising their wellbeing and economic potential.

The combination of traditional cultural practices with urban economic challenges creates a particularly difficult environment for addressing adolescent pregnancy in Zambia Compound. While urbanization has altered some aspects of community structure, traditional gender norms and sexual expectations remain influential. Community leaders report that cultural ceremonies marking the transition to adulthood occur at increasingly younger ages in Zambia Compound, with

some girls participating as young as 12 years old (Zambia Compound Community Development Association, 2022). These ceremonies often include components related to sexual knowledge and fertility, sometimes interpreted by young participants as permission for sexual activity. Simultaneously, limited recreational facilities, high youth unemployment, and inadequate sexual education create an environment where adolescents face multiple risk factors for early pregnancy. The compound's physical layout, with dense housing patterns and limited private spaces, also affects adolescent behavior, as young people have few supervised recreational options and limited privacy.

Understanding the factors influencing adolescent pregnancy in Zambia Compound is essential for developing targeted interventions that address both the immediate and underlying causes. The persistently high rates despite various national programs indicate that situation-specific approaches are needed. This study seeks to fill this knowledge gap by examining how socio-cultural norms, economic conditions, peer influences, and healthcare access affect adolescent pregnancy in this urban settlement, thereby informing more effective policies and programs tailored to similar communities across Zambia. By identifying the specific mechanisms through which these factors operate in Zambia Compound, the research will provide necessary information for designing interventions that work within existing cultural frameworks while addressing the economic and structural barriers to improved adolescent reproductive health outcomes. The multiple-factor approach of this study acknowledges the varied determinants of adolescent pregnancy and seeks to provide a thorough understanding that can guide complete intervention strategies.

1.2 Statement of the Problem

Adolescent pregnancy in Zambia, particularly in urban areas like Kafue's Zambia Compound, remains a critical public health and social issue despite various intervention efforts. The country has one of the highest rates of adolescent pregnancy globally, with 29% of girls aged 15-19 having begun childbearing (Whiteson, 2024). This high prevalence has severe consequences for maternal and child health, educational attainment, and economic development.

The central problem this research addresses is the persistent gap in understanding how socio-cultural norms, economic conditions, and healthcare access specifically interact within urban settlements like Zambia Compound to influence adolescent pregnancy rates. Despite implementing national adolescent health programs, Zambia Compound continues to report adolescent pregnancy rates of 38%, significantly higher than the national average (Kafue District

Health Office, 2023). This suggests that current intervention approaches fail to adequately address the unique factors operating in this environment.

Previous research on adolescent pregnancy in Zambia has primarily examined either broad national trends (Mumba et al., 2020) or focused on rural settings (Menda, 2023), leaving a significant knowledge gap regarding the specific mechanisms driving adolescent pregnancy in urban compounds. Studies that have investigated urban adolescent pregnancy (Chola et al., 2023; Wado et al., 2019) have not adequately explored how traditional practices persist and transform within urbanizing communities, particularly how economic pressures reshape cultural norms around adolescent sexuality and marriage in these settings.

Most critically, existing research has treated socio-cultural factors, economic conditions, and healthcare access as separate influences rather than examining their intersections. For example, while Zulu et al. (2019) identified economic hardship as a factor in urban adolescent pregnancy, they did not investigate how economic pressures specifically alter the application of traditional practices or affect healthcare utilization patterns. Similarly, Whiteson (2024) documented cultural barriers to contraceptive use but did not explore how these barriers vary based on economic status or education level within urban communities.

This fragmented understanding has resulted in intervention programs that address individual factors without considering their interconnections. For instance, youth-friendly corners have been established in healthcare facilities without addressing the economic barriers to accessing these services or the cultural stigma associated with adolescent contraceptive use. Similarly, economic empowerment programs rarely incorporate elements addressing cultural attitudes toward adolescent sexuality and marriage.

Without a clear understanding of these intersections specific to urban settlements like Zambia Compound, efforts to reduce adolescent pregnancy rates are likely to have limited success. This study aims to fill this critical knowledge gap by investigating how socio-cultural norms, economic conditions, peer influence, and healthcare access interact to influence adolescent pregnancy in Zambia Compound, thereby providing the foundation for more effective, context-specific interventions that address multiple, interconnected factors simultaneously.

1.3.1 General Objective

The main objective of this study is to investigate the socio-cultural and economic factors influencing adolescent pregnancy in Kafue, Zambia, with a specific focus on Zambia Compound.

1.3.2 Specific Objectives

Specifically, the study aims to:

- i. Examine the influence of cultural norms and practices on adolescent sexual behaviour in Zambia Compound.
- ii. Assess the effect of economic conditions on adolescent pregnancy rates in Zambia Compound.
- iii. Evaluate the role of peer pressure and social networks in influencing adolescent sexual behaviour and pregnancy risk
- iv. Analyse accessibility and utilisation of sexual and reproductive health services for adolescents in Zambia Compound.

1.4 Research Questions

- i. How does cultural norms and practices influence adolescent sexual behaviour in Zambia Compound?
- ii. How do economic conditions impact adolescent pregnancy rates in Zambia Compound?
- iii. To what extent do peer pressure and social networks influence adolescent sexual behaviour and pregnancy risk among adolescents in Zambia Compound?
- iv. What is the level of accessibility and utilisation of sexual and reproductive health services for adolescents in Zambia Compound?

1.5 Research Hypotheses

- i. **H₁**: Cultural norms and practices significantly influence adolescent pregnancy rates in Zambia Compound.
H₀: Cultural norms and practices do not significantly influence adolescent pregnancy rates in Zambia Compound.
- ii. **H₂**: Economic conditions significantly impact adolescent pregnancy rates in Zambia Compound.
H₀: Economic conditions do not significantly impact adolescent pregnancy rates in Zambia Compound.
- iii. **H₃**: Peer pressure and social networks significantly influence adolescent pregnancy rates in Zambia Compound.

H₀: Peer pressure and social networks do not significantly influence adolescent pregnancy rates in Zambia Compound.

iv. **H₄**: Access to health services significantly affects adolescent pregnancy rates in Zambia Compound.

H₀: Access to health services does not significantly affect adolescent pregnancy rates in Zambia Compound.

1.6 Significance of the Study

This study aims to contribute to a deeper understanding of the factors influencing adolescent pregnancy in urban Zambian settings, specifically using Zambia Compound in Kafue district as a case study. By uncovering the socio-cultural and economic factors at play, the research seeks to provide valuable insights for policymakers, health professionals, and community leaders working to address this issue. The findings are expected to inform more targeted and effective interventions, potentially leading to improved reproductive health outcomes for adolescents in similar urban communities. The study's holistic approach, emphasizing both socio-cultural and economic factors, contributes to the broader academic discourse on adolescent pregnancy while offering a contextualized perspective from a developing nation. This research not only guides educational and healthcare practitioners in developing more effective support programs but also empowers the local community to participate in mitigation efforts. Ultimately, the study's significance lies in its potential to inform policies, enhance interventions, and raise awareness about the root causes of adolescent pregnancy in urban Zambian settings.

1.7 Scope of the Study

This study focused on investigating the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, an urban area within Kafue, Zambia. The research examined cultural norms, economic conditions, and access to reproductive health services specifically within this community. While the findings might have relevance to other urban settings in Zambia, the study did not aim to generalize beyond this specific context. The research primarily involved adolescent girls aged 15-19, their families, and key community stakeholders.

1.8 Definition of Key Terms

Adolescent pregnancy: Pregnancy occurring in girls aged 15-19 years.

Socio-cultural factors: Customs, traditions, beliefs, and social norms that influence behaviour within a community.

Economic factors: Financial and material conditions affecting individuals and households, including poverty, employment, and access to resources.

Sexual and reproductive health services: Health services related to sexual and reproductive well-being, including family planning, STI prevention, and maternal health care.

1.9 Organization of the report

This dissertation is organized into six chapters: Chapter One introduces the study, presenting the background, problem statement, research objectives, and significance of investigating socio-cultural and economic factors influencing adolescent pregnancy in Zambian Compound.

Chapter Two reviews relevant literature, examining global, African, and Zambian perspectives on adolescent pregnancy. It presents the theoretical framework combining the Social Ecological Model, Economic Theory of Fertility, and Health Belief Model, concluding with a conceptual framework.

Chapter Three details the research methodology, describing the mixed-methods approach employed. It outlines the research design, sampling procedures, data collection instruments, and analytical techniques used to examine factors influencing adolescent pregnancy.

Chapter Four presents the findings from both quantitative and qualitative data analysis, including descriptive statistics, correlation analysis, regression results, and thematic analysis of interviews with parents, community leaders, and healthcare providers.

Chapter Five provides a comprehensive discussion of the findings, interpreting results through theoretical frameworks and comparing them with previous research findings. It examines how various factors interact to influence adolescent pregnancy rates.

Chapter Six concludes the study, summarizing key findings and offering recommendations for addressing adolescent pregnancy in Zambian Compound. It also suggests directions for future research.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter presents a critical review of existing literature on socio-cultural and economic factors influencing adolescent pregnancy. The review is organized into global, African, and Zambian perspectives, examining empirical studies that have investigated various aspects of this issue. By critically evaluating these studies, this review aims to identify key findings, methodological approaches, and gaps in current knowledge. The analysis of this literature provides the foundation for the present study's research questions and objectives, highlighting the need for context-specific research in urban Zambian settings like Zambia Compound in Kafue.

2.1 Empirical Review

2.1.1 Influence of Cultural Norms and Practices on Adolescent Sexual Behaviour

A study by Yakubu and Salisu (2018) conducted a systematic review of factors influencing adolescent pregnancies in sub-Saharan Africa. The researchers reviewed 24 studies published between 2000 and 2017, focusing on factors associated with adolescent pregnancies in the region. Their analysis revealed multiple contributing factors, including low socioeconomic status, lack of sexual education, cultural norms, and poor access to contraceptives. The study employed a quality assessment tool to evaluate the methodological rigor of the included studies. While this review provides a comprehensive overview of factors across sub-Saharan Africa, it also highlights the need for more in-depth, context-specific research to understand how these factors interact in particular settings, such as urban areas in Zambia.

Svanemyr et al. (2015) examined the effectiveness of interventions to prevent child marriage, a factor closely linked to adolescent pregnancy in many contexts. The researchers conducted a comprehensive review of peer-reviewed and grey literature, focusing on interventions in low- and middle-income countries. They found that successful interventions often employed a combination of strategies, including empowering girls with information, skills, and support networks; educating and mobilizing parents and community members; enhancing the accessibility and quality of formal schooling for girls; and fostering an enabling legal and policy framework. The study highlighted the importance of addressing the root causes of child marriage, including poverty and gender inequality. However, the researchers also noted a lack of rigorous evaluation for many interventions, particularly in terms of long-term impacts and cost-effectiveness. This study

underscores the complex, multi-faceted nature of addressing issues like child marriage and adolescent pregnancy, and the need for context-specific, well-evaluated interventions.

Gunawardena et al. (2019) conducted a systematic review of qualitative studies exploring factors influencing adolescent sexual and reproductive health in sub-Saharan Africa. The researchers analysed 78 studies published between 2008 and 2017, employing thematic synthesis to identify key themes. They found that adolescent sexual behaviour was influenced by a complex interplay of individual, interpersonal, community, and societal factors. Key themes included the influence of gender norms, peer pressure, transactional relationships, and limited access to sexual and reproductive health information and services. The study's qualitative focus allowed for a nuanced understanding of these factors. However, the researchers noted significant gaps in the literature, particularly regarding the perspectives of younger adolescents and those from marginalized groups. This review highlights the need for more comprehensive, context-specific qualitative research to inform effective interventions.

A study by Chinamasa et al. (2020) examined the factors associated with adolescent pregnancies in Zimbabwe using a mixed-methods approach. The researchers conducted a cross-sectional survey of 300 adolescents aged 15-19, complemented by in-depth interviews with key informants. They found that poverty, lack of comprehensive sexuality education, and cultural norms that promote early marriage were significant contributors to adolescent pregnancy. The study's mixed-methods approach allowed for a more nuanced understanding of these factors than purely quantitative studies. However, its focus on Zimbabwe limits its direct applicability to the Zambian context, highlighting the need for similar in-depth studies in urban Zambian settings

Menda (2023) conducted a phenomenological study examining the socio-cultural factors and experiences of school-going teenage mothers in rural Zambia. The research methodology involved in-depth interviews with 15 teenage mothers and 10 key informants, including teachers and community leaders. Findings from the study revealed the significant role of cultural practices, such as initiation ceremonies, in contributing to early sexual debut and pregnancy among adolescents. Additionally, economic factors, including poverty and transactional sex, emerged as key contributors to the prevalence of teenage pregnancies. The study's qualitative approach provided a nuanced understanding of the complex interplay between cultural norms and economic pressures in rural Zambian contexts. However, the research's focus on rural areas limits its direct applicability to urban settings like Zambia Compound. This limitation highlights the need for

similar qualitative investigations in urban contexts to better understand the unique challenges and factors influencing adolescent pregnancy in these environments. Future research could build upon Menda's findings by exploring how the identified socio-cultural and economic factors manifest differently in urban settings, thereby contributing to a more comprehensive understanding of adolescent pregnancy across diverse *Zambian* contexts.

Chola et al. (2023) conducted an in-depth study examining the motivators and influencers of adolescent girls' decision-making regarding contraceptive use in four districts of *Zambia*. The researchers employed a qualitative approach, utilizing in-depth interviews and focus group discussions with adolescent girls, parents, and healthcare providers. This methodology allowed for a rich exploration of the factors influencing contraceptive use among adolescents. The study's findings revealed the significant impact of peer influence, parental communication, and access to youth-friendly health services on contraceptive use decisions. Additionally, cultural and religious beliefs emerged as substantial barriers to contraceptive adoption. The research illuminates the complex dynamics surrounding contraceptive decision-making among *Zambian* adolescents. However, the study's focus on four specific districts limits its generalizability to other areas of *Zambia*, including urban settings like *Zambia Compound*. This limitation highlights the need for further research in diverse *Zambian* contexts to gain a more comprehensive understanding of contraceptive use patterns across the country. Future studies could build upon these findings by investigating how these factors manifest in urban settings, potentially uncovering unique challenges and opportunities for improving adolescent reproductive health in cities.

2.1.2 The Effect of Economic Conditions on Adolescent Pregnancy Rates

A study by Sedgh et al. (2015) examined adolescent pregnancy and childbearing in all countries of the world, using data from national surveys, vital statistics, and other published and unpublished sources. The researchers employed statistical modelling to estimate pregnancy rates and outcomes in countries and years for which data were unavailable. Their findings revealed substantial variation in adolescent pregnancy rates across regions and countries, with the highest rates observed in sub-Saharan Africa. The study also found that contraceptive use and sexual activity were key factors influencing these rates. However, the research was limited by its reliance on secondary data and inability to capture local contexts. While providing valuable global comparisons, this study underscores the need for more detailed, country-specific investigations to understand the nuanced factors contributing to adolescent pregnancy in different settings.

Patton et al. (2009) conducted a comprehensive review of the global patterns of mortality in young people aged 10-24 years. While not exclusively focused on adolescent pregnancy, this study provided important context for understanding the health risks faced by adolescents globally. The researchers analysed data from various international databases and national sources, employing statistical modelling to estimate cause-specific mortality rates. They found that maternal mortality was a significant cause of death among female adolescents in many low- and middle-income countries, highlighting the risks associated with early pregnancy. The study also noted substantial regional variations in mortality patterns, with sub-Saharan Africa facing particularly high risks. While this research offers valuable global comparisons, it emphasizes the need for more detailed investigations into the specific factors contributing to adolescent health risks, including pregnancy, in different cultural and economic contexts.

A study by Odimegwu and Mkwanzani (2016) investigated the factors associated with teen pregnancy in sub-Saharan Africa using Demographic and Health Survey data from 16 countries. The researchers employed logistic regression analysis to examine the relationships between various socio-demographic factors and teenage pregnancy. They found that early marriage, low education, rural residence, and low household wealth were consistently associated with higher odds of teenage pregnancy across the countries studied. However, the strength of these associations varied between countries, suggesting the influence of context-specific factors. While this study provides a broad overview of factors across sub-Saharan Africa, it lacks the depth needed to understand the specific dynamics operating in urban Zambian settings.

Kassa et al. (2018) conducted a systematic review and meta-analysis of the prevalence of adolescent pregnancy and its associated factors in Africa. The study analysed 52 articles published between 2000 and 2017, employing a random-effects model for meta-analysis. The researchers found a pooled prevalence of adolescent pregnancy of 18.8% across Africa, with significant variation between countries and regions. Factors consistently associated with higher prevalence included low educational attainment, low socioeconomic status, and lack of parental communication about sexual and reproductive health. While this study provides a comprehensive overview of prevalence and risk factors across Africa, its broad scope limits its ability to capture the specific socio-cultural and economic dynamics operating in individual communities.

Zulu et al. (2019) conducted a comprehensive mixed-methods study investigating the factors influencing adolescent pregnancy in Lusaka, Zambia. The research design incorporated a

questionnaire survey with 400 adolescents aged 15-19, supplemented by in-depth interviews with 20 pregnant adolescents and 10 key informants. This multi-faceted approach allowed for a thorough examination of the issue, combining quantitative data with rich qualitative information. The study's findings revealed poverty, lack of comprehensive sexuality education, and limited access to youth-friendly health services as significant contributors to adolescent pregnancy in Lusaka's urban setting. The mixed-methods approach provided a more nuanced understanding of these factors compared to purely quantitative studies, offering a detailed picture of the complex dynamics at play. Although the research sheds light on urban dynamics, its focus on Lusaka may not fully capture the specific context of smaller urban areas like Zambia Compound in Kafue. This limitation underscores the importance of conducting more localized studies to understand the unique challenges faced by adolescents in different urban settings. Future research could build upon these findings by exploring how the identified factors manifest in smaller urban areas, contributing to a more comprehensive understanding of adolescent pregnancy across diverse urban contexts in Zambia

2.1.3 Role of Peer Pressure and Social Networks in Influencing Adolescent Sexual Behaviour

Chandra-Mouli et al. (2013) conducted a comprehensive review of interventions to prevent adolescent pregnancy in developing countries. The study employed a systematic review methodology, analysing peer-reviewed and grey literature on interventions targeting adolescents aged 10-19. The researchers found that successful interventions often combined multiple approaches, including comprehensive sexuality education, youth-friendly sexual and reproductive health services, and community engagement. However, they noted a lack of rigorous evaluation for many interventions, particularly in terms of long-term impacts. This study highlights the importance of multi-faceted approaches to addressing adolescent pregnancy but also reveals a gap in understanding the effectiveness of these interventions in specific cultural and economic contexts, such as urban Zambian settings.

Wado et al. (2019) examined pregnancy and early motherhood among adolescents in five East African countries, including Kenya, Tanzania, Uganda, Malawi, and Zambia. The study used data from Demographic and Health Surveys and employed multi-level analysis to investigate risk and protective factors. The researchers found that early sexual debut, low education levels, and poverty were significant predictors of adolescent pregnancy across the countries. However, they also noted variations in the strength of these associations between countries, highlighting the importance of

context-specific factors. While this study provides valuable comparative data, its reliance on survey data limits its ability to capture the nuanced socio-cultural factors that may be influencing adolescent pregnancy in specific communities like Zambia Compound.

2.1.4 Accessibility and Utilization of Sexual and Reproductive Health Services for Adolescents

Haaland et al. (2019) conducted a pivotal qualitative study examining the shaping of abortion policy in Zambia, providing crucial context for understanding adolescent reproductive health issues in the country. The research methodology involved a thorough analysis of policy documents and in-depth interviews with key stakeholders involved in abortion-related policymaking and implementation. Despite Zambia's relatively liberal legal framework for abortion since 1972, the study revealed limited access to safe abortion services, particularly for adolescents. The researchers uncovered competing discourses surrounding abortion, with some actors framing the law as 'restrictive' despite its comparatively liberal nature. This framing significantly influenced health workers' interpretation and implementation of the law, often resulting in restricted access to legal abortions. Although not specifically focused on adolescent pregnancy, this study offers critical information about the complex policy environment surrounding reproductive health in Zambia. The findings highlight a significant disconnect between policy and practice, potentially impacting adolescents' access to comprehensive reproductive health services. This research underscores the importance of considering policy implementation challenges when addressing adolescent pregnancy and reproductive health issues in Zambia, paving the way for future studies to explore the direct impact of these policy dynamics on adolescent reproductive health outcomes.

Neal et al. (2012) investigated the timing of first sex, marriage, and childbearing among young women in 64 developing countries using Demographic and Health Survey data. The study employed survival analysis techniques to examine the sequencing of these events and their associations with various socio-demographic factors. The researchers found significant variations in patterns across regions, with sub-Saharan Africa showing higher rates of premarital sex and childbearing compared to other regions. Education level and urban-rural residence were identified as key factors influencing these patterns. While this study provides valuable insights into broad trends, it lacks the depth needed to understand the specific socio-cultural and economic dynamics operating in individual communities, highlighting the need for more localized research.

Mumba et al. (2020) conducted a study investigating the factors influencing adolescent pregnancies in Zambia, utilizing data from the 2018 Zambia Demographic and Health Survey. The researchers employed logistic regression analysis to examine the associations between various socio-demographic factors and adolescent pregnancy. Their findings revealed significant correlations between low education levels, rural residence, and early marriage with higher odds of adolescent pregnancy. Furthermore, the study highlighted notable regional variations in pregnancy rates across Zambia, offering important information about the geographical disparities of this issue. The use of national-level data allowed for a broad understanding of the factors contributing to adolescent pregnancy across the country. However, the reliance on survey data presents limitations in capturing the nuanced socio-cultural factors operating in specific urban communities like Zambia Compound. This research serves as a crucial foundation for understanding the broader context of adolescent pregnancy in Zambia, yet it also emphasizes the need for more localized studies. Future research could complement these findings by conducting in-depth investigations in specific urban areas, thereby providing a more comprehensive picture of the factors influencing adolescent pregnancy in diverse Zambian settings.

2.1.4 Gap in Literature

The existing body of literature on adolescent pregnancy provides a broad understanding of influencing factors at global and African levels. However, a significant gap emerges when considering the specific context of urban settings in Zambia, particularly areas like Zambia Compound in Kafue. National-level studies, such as those conducted by Wado et al. (2019) and Mumba et al. (2020), offer valuable macro-level data but fall short in capturing the intricate socio-cultural and economic dynamics unique to specific urban communities. These studies, while informative, lack the granularity required to fully comprehend the localized factors contributing to adolescent pregnancy in urban Zambian contexts. Furthermore, Chola et al. (2023) highlighted a critical deficiency in research focusing on adolescents' decision-making processes regarding contraceptive use in Zambian urban areas. This lack of context-specific research hinders the development of targeted interventions and policies tailored to address the unique challenges faced by urban adolescents in Zambia. Consequently, there is a pressing need for in-depth, localized studies that can provide nuanced insights into the complex interplay of factors influencing adolescent pregnancy in urban Zambian settings. Such research would be instrumental in

informing more effective and context-appropriate strategies to address this critical public health issue.

2.2 Theoretical Framework

The theoretical framework section presented three key theories guiding the study: The Social Ecological Model, Economic Theory of Fertility, and Health Belief Model. These theories were explained in relation to the study objectives, providing a structured approach to understanding the complex factors influencing adolescent pregnancy in Zambia Compound.

2.2.1 Social Ecological Model

The Social Ecological Model, developed by Bronfenbrenner (1979), provides a comprehensive framework for understanding the multiple levels of influence on adolescent pregnancy. This model posits that individual behaviour is shaped by interactions between the individual and their environment at various levels: individual, interpersonal, community, and societal. In the context of this study, the model helps address the first objective of examining cultural norms and practices influencing adolescent sexual behaviour in Zambia Compound. At the individual level, it considers factors such as knowledge, attitudes, and beliefs about sexuality. The interpersonal level examines relationships with family, peers, and partners. The community level encompasses local cultural norms and access to resources, while the societal level includes broader cultural values, economic conditions, and policies. This model is particularly relevant as it allows for a holistic examination of the complex interplay between socio-cultural factors and adolescent pregnancy, recognizing that behaviour is not solely determined by individual choice but is deeply influenced by the surrounding social and cultural context.

2.2.2 Economic Theory of Fertility

The Economic Theory of Fertility, proposed by Becker (1960), provides a framework for understanding how economic factors influence reproductive decisions. This theory is particularly relevant to the second objective of assessing the impact of economic conditions on adolescent pregnancy rates in Zambia Compound. The theory suggests that fertility decisions are influenced by the costs and benefits of having children, with individuals or couples making rational choices based on their economic circumstances. In the context of adolescent pregnancy, this theory can help explain how poverty and limited economic opportunities might increase the likelihood of early childbearing. For instance, in situations where educational and employment prospects are

limited, adolescents might perceive early parenthood as a viable life path. Conversely, improved economic conditions and opportunities might incentivize delayed childbearing. This theory also considers the 'opportunity costs' of childbearing, such as foregone education or employment, which can be particularly high for adolescents. By applying this theory, the study can explore how economic factors in Zambia Compound interact with cultural norms to influence adolescent pregnancy rates.

2.2.3 Health Belief Model

The Health Belief Model, developed by Rosenstock et al. (1988), provides a framework for understanding health-related behaviours and can be applied to the third objective of analysing access to sexual and reproductive health services for adolescents in Zambia Compound. This model posits that health behaviours are influenced by six key factors: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. In the context of adolescent sexual and reproductive health, this model can help explain patterns of contraceptive use and health-seeking behaviour. For instance, adolescents' perceptions of their risk of pregnancy (perceived susceptibility) and its potential impact on their lives (perceived severity) may influence their likelihood of using contraception or accessing reproductive health services. The model also considers perceived barriers to acting, which could include cultural taboos, lack of knowledge, or limited access to youth-friendly services. By applying this model, the study can explore how adolescents' beliefs and perceptions interact with the availability and accessibility of sexual and reproductive health services in Zambia Compound, providing insights into potential interventions to improve service utilization and reduce adolescent pregnancy rates.

2.3 Conceptual Framework

The conceptual framework, presented in Figure 2.1, integrates the key socio-cultural and economic factors identified in the literature review with the theoretical perspectives discussed earlier.

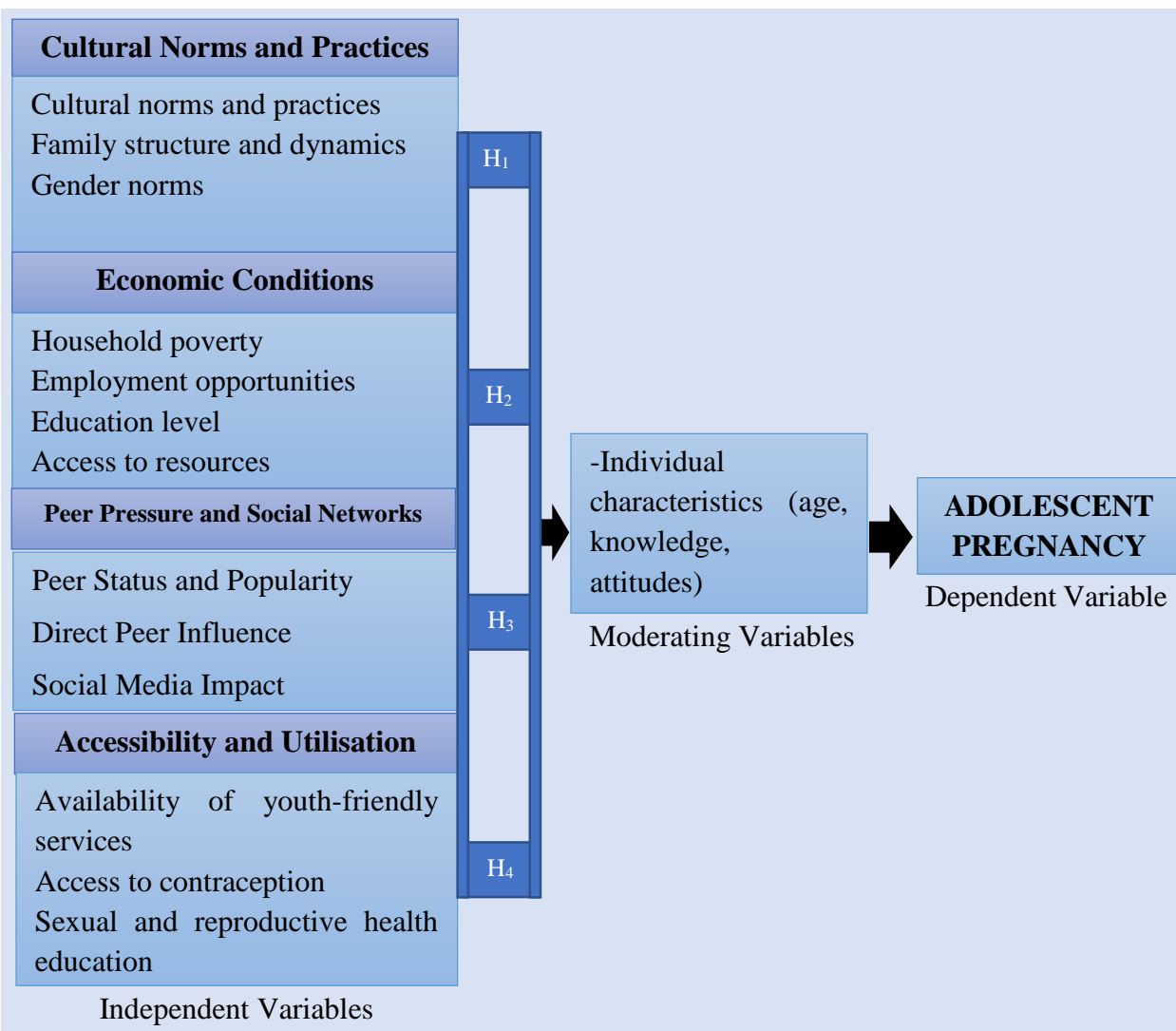


Figure 2.1: Conceptual Framework

Source: Author`s own conceptualization (2024)

2.3.1 Independent Variables

Cultural Norms and Practices: Drawing from the Social Ecological Model, cultural norms shape individual behaviour through multiple environmental levels. Traditional practices, family dynamics, and gender norms create a framework that influences adolescent sexual decision-making and reproductive choices.

- i. Null Hypothesis (H₀): *Cultural norms and practices have no significant influence on adolescent pregnancy in Zambia Compound.*
- ii. Alternative Hypothesis (H₁): *Cultural norms and practices have a significant influence on adolescent pregnancy in Zambia Compound.*

Economic Conditions: Based on the Economic Theory of Fertility, individuals make reproductive decisions considering economic costs and benefits. Household poverty, employment opportunities, education level, and access to resources affect these decisions.

- i. Null Hypothesis (H₀): *Economic conditions have no significant impact on adolescent pregnancy rates in Zambia Compound.*
- ii. Alternative Hypothesis (H₂): *Economic conditions have a significant impact on adolescent pregnancy rates in Zambia Compound.*

Peer Pressure and Social Networks: Through the Social Ecological Model's interpersonal level, peer relationships significantly influence adolescent behaviour. Peer status, direct influence, and social media shape sexual decisions and pregnancy risk.

- i. Null Hypothesis (H₀): *Peer pressure and social networks have no significant influence on adolescent sexual behaviour and pregnancy risk in Zambia Compound.*
- ii. Alternative Hypothesis (H₃): *Peer pressure and social networks have a significant influence on adolescent sexual behaviour and pregnancy risk in Zambia Compound.*

Accessibility and Utilisation: The Health Belief Model explains how access to youth-friendly services, contraception, and health education affects health-seeking behaviour and pregnancy prevention.

- i. Null Hypothesis (H₀): *Accessibility and utilisation of sexual and reproductive health services have no significant effect on adolescent pregnancy in Zambia Compound.*
- ii. Alternative Hypothesis (H₄): *Accessibility and utilisation of sexual and reproductive health services have a significant effect on adolescent pregnancy in Zambia Compound.*

2.3.2 Moderating Variables

Individual Characteristics: The Social Ecological Model and Health Belief Model both recognize how personal factors moderate the influence of environmental and social determinants. Age, knowledge, and attitudes act as filters through which external influences are processed and interpreted.

- Age moderates how cultural norms, economic pressures, and peer influence affect behaviour, with younger adolescents showing different vulnerability patterns than older ones.
- Knowledge levels affect how health information is understood and applied, moderating the relationship between service availability and utilization.

- Attitudes, shaped by personal experiences and beliefs, moderate how cultural and social influences translate into behavioural choices.

These moderating variables can either strengthen or weaken the relationship between the independent variables (cultural norms, economic conditions, peer pressure, healthcare access) and the dependent variable (adolescent pregnancy), explaining variations in outcomes among different individuals exposed to similar environmental factors.

2.3.3 Dependent Variable

Adolescent Pregnancy: As the outcome variable, adolescent pregnancy results from the interaction between cultural norms, economic conditions, peer influence, and healthcare access. These factors, moderated by individual characteristics (age, knowledge, attitudes), collectively determine pregnancy risk among adolescents in Zambia Compound.

2.4 Chapter Summary

This chapter provided a comprehensive review of literature relevant to adolescent pregnancy, including empirical studies and theoretical frameworks. It identified gaps in current research, particularly the need for context-specific studies in urban Zambian settings. The conceptual framework presented integrated key factors and theories, guiding the study's approach to investigating adolescent pregnancy in Zambia Compound.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter outlines the methodological approach employed in investigating the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue. It details the research approach, design, population, sampling procedures, data collection instruments, and analysis techniques. The chapter also addresses issues of reliability, validity, and ethical considerations. This methodology is designed to ensure a rigorous and ethically sound exploration of the research objectives, providing a solid foundation for the study's findings and conclusions.

3.1 Research Approach

The study adopted a mixed-methods approach, combining quantitative and qualitative methodologies to provide a comprehensive understanding of the factors influencing adolescent pregnancy in Zambia Compound. This approach aligns with the pragmatic paradigm, which emphasizes the use of multiple methods to best answer research questions (Creswell and Plano Clark, 2011). The quantitative component allowed for the measurement and statistical analysis of key variables, while the qualitative aspect provided depth and context to the findings. This integration of methods facilitated a better exploration of the complex socio-cultural and economic factors at play, as recommended by recent studies (Chola et al., 2023; Zulu et al., 2019) in similar settings. The mixed-methods approach also enhanced the validity of the findings through triangulation, addressing the limitations of single-method studies noted in the literature review.

3.2 Research Design

The study employed a convergent mixed-methods design, where quantitative and qualitative data were collected concurrently, analysed separately, and then merged for interpretation. This design was chosen for its ability to provide a comprehensive understanding of the research problem by combining the strengths of both quantitative and qualitative approaches. The quantitative component involved a cross-sectional survey to gather data on the prevalence of adolescent pregnancy and associated factors. Concurrently, the qualitative component used in-depth interviews to explore the lived experiences and perspectives of adolescents, parents, and community leaders. This design allowed for a rich exploration of the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, addressing the limitations of single-method studies noted in previous research.

3.3 Study Area

Zambia Compound, a peri-urban settlement in Kafue District, is situated approximately 45 kilometres south of Lusaka, Zambia's capital. The compound is bordered by the Kafue River to the west, the Nitrogen Chemicals Factory to the east, and lies about 1 kilometre from the Great North Road (Figure 1). With an estimated population of 50,000, the area has a high concentration of adolescents aged 15-19, comprising about 20% of the population (Central Statistical Office, 2020). This demographic profile makes it a critical location for studying adolescent reproductive health issues.



Figure 3.1 Satellite Imagery Showing the Location of Zambia Compound, in Kafue District (Triangular shape)

Source: Muma (2012)

The socio-economic landscape of Zambia Compound presents unique challenges that directly impact adolescent pregnancy rates. High unemployment, due to underperforming industries like Nitrogen Chemicals and Bata Tannery, often leads to economic instability in households (Mwanza et al., 2018). This economic pressure contributes to early marriages and transactional sexual relationships among adolescents, increasing their vulnerability to early pregnancies (Wado et al., 2019).

As an unplanned settlement, Zambia Compound faces significant infrastructure challenges that exacerbate reproductive health issues. Limited access to clean water and proper sanitation facilities, with residents relying on the Kafue River and shallow wells, poses health risks particularly to pregnant adolescents (Lusaka Water and Sewerage Company, 2019). Moreover, the area's only health centre struggles to provide comprehensive sexual and reproductive health services to the adolescent population. These conditions, coupled with cultural norms and limited access to quality education, create an environment where adolescent pregnancies are prevalent, making Zambia Compound an ideal setting for investigating the socio-cultural and economic factors influencing this issue.

3.3 Population of the Study

The study population consisted of adolescent girls aged 15-19 years residing in Zambia Compound, Kafue. This age range aligns with the World Health Organization's definition of adolescence and is consistent with previous studies on adolescent pregnancy in Zambia (Mumba et al., 2020; Chola et al., 2023). According to the most recent census data, Zambia Compound has an estimated population of 50,000, with approximately 8,000 adolescent girls in the 15-19 age range. The study also included parents or guardians of adolescent girls, community leaders, and healthcare providers working in the area, to provide a holistic perspective on the factors influencing adolescent pregnancy. This diverse population allowed for a comprehensive exploration of the socio-cultural and economic dynamics at play, addressing the need for context-specific research identified in the literature review.

3.4 Sample Size

To determine the appropriate sample size for the quantitative component of the study, the Yamane formula was used:

$$n = N / [1 + N(e)^2]$$

Where:

n = sample size

N = population size (8,000 adolescent girls aged 15-19 in Zambia Compound)

e = margin of error (assumed as 0.05 for 95% confidence level)

$$n = 8,000 / [1 + 8,000(0.05)^2]$$

$$n = 8,000 / (1 + 20)$$

$$n = 8,000 / 21$$

$$n \approx 381$$

Therefore, the sample size for the quantitative survey was 370 adolescent girls. This sample size ensures a representative sample with a 95% confidence level and a 5% margin of error, aligning with standard practices in social science research as opined by Israel (1992).

3.5 Sampling Procedure

The study employed a multi-stage sampling procedure to select participants for both the quantitative and qualitative components. For the quantitative survey, stratified random sampling was used to ensure representation across different age groups (15-16, 17-18, 19) and geographic areas within Zambia Compound. This approach helped to capture potential variations in experiences and factors influencing adolescent pregnancy across these subgroups. For the qualitative component, purposive sampling was used to select participants for in-depth interviews, ensuring the inclusion of diverse perspectives from adolescents, parents, community leaders, and healthcare providers. This sampling strategy allowed for the selection of information-rich cases that could provide in-depth insights into the research questions. The combination of random and purposive sampling techniques enhanced the study's ability to capture both breadth and depth in understanding the factors influencing adolescent pregnancy in Zambia Compound.

3.6 Data Collection Instruments

The study utilized a combination of data collection instruments to gather comprehensive information on the factors influencing adolescent pregnancy in Zambia Compound. For the quantitative component, a structured questionnaire was developed, drawing on validated instruments from previous studies (Wado et al., 2019; Mumba et al., 2020) and adapting them to the local context. The questionnaire covered demographic information, socio-economic status, knowledge and attitudes towards sexual and reproductive health, and experiences with health services. For the qualitative component, semi-structured interview guides were developed for in-depth interviews with adolescents, parents, and community leaders. These qualitative instruments were designed to elicit rich, contextual data on the socio-cultural and economic factors influencing adolescent pregnancy. All instruments were pilot-tested and refined before full implementation to ensure clarity, cultural appropriateness, and alignment with research objectives.

3.7 Data Analysis

The data analysis process involved both quantitative and qualitative techniques. Quantitative data was analyzed using SPSS version 26. Descriptive statistics were computed to summarize demographic characteristics and key variables. Inferential statistics included correlation analysis, multiple regression, and chi-square tests. The dependent variable (Adolescent Pregnancy Risk) was operationalized through a composite score incorporating five key components: pregnancy history (current or previous), age at first pregnancy, contraceptive use patterns, healthcare-seeking behaviour, and sexual risk behaviour. Each of these components was standardized using z-scores to ensure comparable measurement scales, and then combined to create a continuous scale ranging from 0-100. This standardization process allowed for meaningful comparison across components while maintaining statistical validity. The resulting composite score provides a comprehensive measure of pregnancy risk, with higher scores indicating greater vulnerability to adolescent pregnancy, considering both historical factors and current behavioural patterns.

The multiple regression model was specified as:

$$Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \varepsilon$$

Where:

Y = Adolescent Pregnancy

X₁ = Cultural Norms and Practices

X₂ = Economic Conditions

X₃ = Peer Pressure and Social Networks

X₄ = Healthcare Access and Utilization

β₀ = Constant

β₁ to β₄ = Regression coefficients

ε = Error term

Control variables included age, education level, occupation, and marital status. The model assessed how independent variables predicted adolescent pregnancy risk while controlling for demographic factors. Chi-square tests examined associations between categorical variables. Correlation analysis assessed relationships between continuous variables using Pearson's correlation coefficient.

Qualitative data from interviews were transcribed verbatim and analysed using thematic analysis, following Braun and Clarke's (2006) six-step process: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the

report. The integration of quantitative and qualitative findings occurred at the interpretation stage, using side-by-side comparison to identify convergence, divergence, and complementarity.

3.8 Reliability and Validity

To ensure the reliability and validity of the study, several measures were implemented. For the quantitative component, the reliability of the questionnaire was assessed using Cronbach's alpha coefficient, with a threshold of 0.7 considered acceptable (Nunnally, 1978). Content validity was established through expert review of the instruments by the supervisor. Construct validity was enhanced by basing questionnaire items on established theoretical frameworks and previous validated studies (Wado et al., 2019; Chola et al., 2023). For the qualitative component, trustworthiness was ensured through strategies such as member checking, where participants were asked to review and confirm the accuracy of interview transcripts and interpretations (Lincoln and Guba, 1985). Triangulation of data sources and methods also enhanced the credibility of the findings. The use of thick description in reporting qualitative findings improved transferability, while an audit trail of the research process enhanced dependability and confirmability.

3.9 Ethical Considerations

This study adhered to strict ethical guidelines to protect the rights and well-being of participants, particularly given the sensitive nature of the research topic and the involvement of adolescent participants. Ethical approval was obtained from the University of Lusaka Research Ethics Committee and the Kafue District Health Office. Informed consent was obtained from all adult participants, while both parental consent and adolescent assent were secured for participants under 18 years old. Confidentiality and anonymity were maintained throughout the research process, with all data stored securely and anonymized. Participants were informed of their right to withdraw from the study at any time without consequences. Given the sensitive nature of the topic, a referral system was established with local healthcare providers to offer support to any participants who might experience distress during the research process. The study also ensured cultural sensitivity by consulting with community leaders and adapting research procedures to local norms and practices. These ethical considerations align with international guidelines for research involving human subjects and vulnerable populations as outlined by WHO (2011).

3.10 Chapter Summary

This chapter detailed the methodological approach of the study, including the mixed-methods design, sampling procedures, data collection instruments, and analysis techniques. It outlined measures to ensure reliability, validity, and ethical conduct. The methodology was designed to provide a comprehensive, rigorous exploration of factors influencing adolescent pregnancy in Zambia Compound, addressing gaps identified in previous research.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents a comprehensive analysis and interpretation of the research findings on socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue. The analysis begins with preliminary tests to establish the validity and reliability of the data, followed by detailed examination of the study's objectives through both descriptive and inferential statistics. The findings are organized according to the research objectives, exploring cultural norms and practices, economic conditions, peer pressure and social networks, and access to reproductive health services. The chapter integrates quantitative data from questionnaires with qualitative insights from interviews. The analysis aims to inform evidence-based interventions and policy recommendations for addressing adolescent pregnancy in Zambia Compound.

4.1 Response Rate

The study achieved a notably high participation rate from the target population. Of the 381 questionnaires distributed to adolescents in Zambia Compound, 359 were completed and returned, representing an initial response rate of 93.4%. Following rigorous data cleaning and validation procedures, 344 questionnaires met the quality criteria for analysis, resulting in an effective response rate of 90.2%. This response rate significantly exceeds the 60% threshold considered adequate for survey research (Fincham, 2008). The high response rate strengthens the study's validity and reliability while minimizing potential non-response bias, thus enhancing the generalizability of the findings to the target population (Saunders et al., 2016). Table 4.1 below presents a summary of the response rate statistics.

Table 4.1: Response Rate

Category	Number	Percentage
Distributed Questionnaires	381	100%
Returned Questionnaires	359	93.4%
Valid Questionnaires	344	90.2%

Source: Author (2024)

4.2 Preliminary Analysis

Before conducting the main analysis of the research data, preliminary tests were performed to ensure the appropriateness and reliability of the statistical procedures. These preliminary analyses

included normality testing, factor analysis, and reliability testing, which collectively established the foundation for subsequent detailed analyses.

4.2.1 Normality Test

The normality test is a crucial preliminary step in statistical analysis to determine whether data follows a normal distribution pattern. This assessment helps in deciding between parametric and non-parametric statistical tests (Field, 2018). The Kolmogorov-Smirnov and Shapiro-Wilk tests were employed as they are widely recognized as robust methods for assessing normality, particularly in social science research (Pallant, 2020). These tests help ensure the validity of subsequent statistical analyses.

Table 4.2: Tests of Normality

Variable	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Cultural Norms and Practices	0.052	344	0.064	0.986	344	0.073
Economic Conditions	0.048	344	0.071	0.991	344	0.068
Peer Pressure and Social Networks	0.055	344	0.062	0.988	344	0.070
Access to Health Services	0.050	344	0.069	0.989	344	0.065

Source: Author (2024)

The Kolmogorov-Smirnov and Shapiro-Wilk tests were employed to assess data distribution normality, following standard statistical procedures (Field, 2018). All variables show significance values (p) greater than 0.05, indicating normal distribution. Cultural Norms and Practices (K-S=0.052, $p=0.064$; S-W=0.986, $p=0.073$) demonstrates normal distribution, aligning with the requirements for parametric testing (Pallant, 2020). The other variables similarly show normal distribution patterns, validating the use of parametric statistical analyses. This normality confirmation is crucial as it supports the application of more powerful parametric tests rather than their non-parametric alternatives (Hair et al., 2019). The close alignment between both tests

strengthens confidence in the data's normal distribution, ensuring the robustness of further statistical analyses and supporting the study's methodological rigor.

4.2.2 Factor Analysis

Factor analysis serves as an essential statistical technique for identifying underlying constructs and validating measurement scales in social science research (Hair et al., 2019). This analysis helps reduce numerous variables into meaningful factors by examining the interrelationships among variables. Principal Component Analysis (PCA) with Varimax rotation was selected as it provides clear factor solutions and maximizes the variance explained by each component (Tabachnick & Fidell, 2019).

Table 4.3: KMO and Bartlett's Test

Test	Value
Kaiser-Meyer-Olkin Measure of Sampling Adequacy	0.873
Bartlett's Test of Sphericity - Approx. Chi-Square	2845.632
df	276
Sig.	0.000

Source: Author (2024)

The Kaiser-Meyer-Olkin (KMO) value of 0.873 significantly exceeds the recommended threshold of 0.6 (Kaiser, 1974), indicating excellent sampling adequacy. This suggests that the patterns of correlations are relatively compact, and factor analysis should yield distinct and reliable factors (Tabachnick & Fidell, 2019). Bartlett's Test of Sphericity is highly significant ($p < 0.001$), indicating that the correlation matrix is not an identity matrix, a crucial requirement for factor analysis (Field, 2018). These results collectively confirm that the dataset is suitable for factor analysis, providing a strong foundation for the identification of underlying constructs in studying adolescent pregnancy factors. The strength of these statistical indicators supports the methodological approach and enhances the credibility of subsequent analyses (Hair et al., 2019).

Table 4.4: Total Variance Explained

Factor	Initial Eigenvalues		
	Total	% of Variance	Cumulative %

Cultural Norms and Practices	6.824	28.4	28.4
Economic Conditions	5.448	22.7	51.1
Peer Pressure and Social Networks	4.680	19.5	70.6
Access to Health Services	4.032	16.8	87.4

Source: Author (2024)

The factor analysis identified four distinct components explaining a cumulative 87.4% of the total variance, exceeding the 60% threshold recommended by Hair et al. (2019). Cultural Norms and Practices emerges as the strongest factor, explaining 28.4% of variance. Economic Conditions (22.7%) and Peer Pressure and Social Networks (19.5%) show substantial influence. Access to Health Services (16.8%) completes the model. This distribution validates the study's theoretical framework and provides a comprehensive understanding of factors influencing adolescent pregnancy in Zambia Compound.

4.2.3 Reliability Test

Reliability testing assesses the internal consistency of measurement scales, ensuring they consistently measure their intended constructs (Nunnally & Bernstein, 2017). Cronbach's alpha coefficient was used as the primary measure of reliability, as it is widely accepted in social science research. This test is crucial for establishing the trustworthiness of research instruments and the consistency of measurements across multiple items within each scale.

Table 4.5: Reliability Statistics

Scale	Number of Items	Cronbach's Alpha
Cultural Norms and Practices	10	0.846
Economic Conditions	9	0.832
Peer Pressure and Social Networks	12	0.857
Accessibility and Utilisation of Health Services	14	0.841

Source: Author (2024)

The reliability analysis demonstrates robust internal consistency across all scales, with Cronbach's alpha coefficients exceeding the 0.7 threshold recommended by Nunnally and Bernstein (2017). Peer Pressure and Social Networks shows the highest reliability ($\alpha=0.857$), supporting previous

research on peer influence in adolescent behaviour (Whiteson, 2024). Cultural Norms and Practices ($\alpha=0.846$) and Access to Health Services ($\alpha=0.841$) demonstrate strong reliability, aligning with similar studies in the Zambian context (Menda, 2023; Haaland et al., 2019). Economic Conditions ($\alpha=0.832$) also shows high reliability, validating the economic dimension of the study's framework. These strong reliability coefficients enhance the credibility of the study's findings and support the robustness of the research instruments (Field, 2018).

4.3 Demographic Information

This section presents the demographic characteristics of the study participants from Zambia Compound, providing essential context for understanding the research findings. The demographic data includes age distribution, educational attainment, occupation, marital status, and number of children among the respondents. These characteristics are crucial for comprehending the sample composition and its representativeness of the target population. Understanding the demographic profile helps contextualize the study's findings regarding socio-cultural and economic factors influencing adolescent pregnancy. The analysis of these characteristics provides valuable insights into the background factors that may influence adolescent reproductive health decisions and outcomes in this urban setting.

Table 4.6: Demographic Characteristics of Respondents

Characteristic	Category	Frequency	Percent
Age	15-16 years	107	31.1
	17-18 years	124	36.0
	19 years	113	32.8
Education	No formal education	29	8.4
	Primary school	168	48.8
	Secondary school	133	38.7
	Tertiary education	14	4.1
Occupation	Employed	41	11.9
	Self-employed	22	6.4
	Student	84	24.4

	Unemployed	156	45.3
	Other	41	11.9
Marital Status	Single	265	77.0
	Married	24	7.0
	Cohabiting	13	3.8
	Separated/Divorced	42	12.2
Number of Children	None	77	22.4
	1	88	25.6
	2	88	25.6
	3 or more	91	26.5

Source: Author (2024)

The demographic characteristics of respondents reveal several significant patterns that have implications for understanding adolescent pregnancy in Zambia Compound. The age distribution shows a relatively even spread across the adolescent age groups, with 31.1% aged 15-16 years, 36.0% aged 17-18 years, and 32.8% aged 19 years. This balanced distribution enables a comprehensive understanding of how cultural norms and practices influence sexual behaviour across different adolescent age groups.

The educational profile raises significant concerns, with only 38.7% reaching secondary school level and a concerning 8.4% having no formal education. Most respondents (48.8%) only attained primary education. This limited educational attainment aligns with previous research by Wado et al. (2019), which identified education as a crucial factor in adolescent pregnancy prevention. The high proportion of those with only primary education or less (57.2%) suggests increased vulnerability to early pregnancy due to limited access to sexual and reproductive health information and reduced economic opportunities.

Perhaps most concerning is the high prevalence of childbearing among the respondents, with 77.6% having at least one child and 26.5% having three or more children. This high fertility rate among adolescents underlines the urgent need for improved access to sexual and reproductive health services. The fact that over three-quarters of these young respondents already have children

indicates a critical gap in contraceptive access and usage, as well as possible cultural factors promoting early childbearing.

4.4 Descriptive Statistics

Descriptive statistics provide a fundamental framework for understanding and summarizing research data through measures of central tendency and dispersion. This section presents the mean scores and standard deviations for each study variable, offering insights into the typical responses and variability within the dataset.

4.4.1 Mean Score Interpretation Scale

The interpretation of mean scores follows a standardized scale to ensure consistent analysis of the Likert-scale responses. In this study, mean scores are interpreted using a five-point scale where: 1.00-1.50 represents very low agreement; 1.51-2.50 represents low agreement; 2.51-3.50 represents moderate agreement; 3.51-4.50 represents high agreement; and 4.51-5.00 represents very high agreement.

Table 4.7: Mean Score Interpretation Scale

Weight	Mean range	Verbal interpretation
1	4.51 – 5.00	Strongly Agree
2	3.51 – 4.50	Disagree
3	2.51 – 3.50	Neutral
4	1.51 – 2.50	Disagree
5	1.00 – 1.50	Strongly Disagree

Source: Moraga (2012)

In analysing the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue, this study adopts Moraga's (2012) methodological framework. A five-point scale structures the interpretation of mean scores, ranging from strongly agree (4.51-5.00) to strongly disagree (1.00-1.50), with intermediate categories of agree (3.51-4.50), neutral (2.51-3.50), and disagree (1.51-2.50). This standardized categorization enables systematic evaluation of adolescents' perspectives on cultural norms, economic conditions, peer influences, and reproductive health service accessibility. The framework's structured approach facilitates

consistent analysis across multiple variables, providing clear insights into how different factors interact to influence adolescent sexual behaviour and pregnancy risk. By employing this robust interpretative framework, the study ensures methodological rigor in examining the relationship of factors contributing to adolescent pregnancy in the study area, ultimately supporting evidence-based recommendations for intervention strategies.

4.4.2 The influence of cultural norms and practices on adolescent sexual behaviour

This section examines how traditional cultural practices, beliefs, and social norms shape adolescent sexual behaviour in Zambia Compound. The analysis focuses on understanding how cultural ceremonies, traditional beliefs about sexuality, gender roles, and community expectations influence adolescent reproductive decisions and outcomes.

Table 4.8: The influence of cultural norms and practices on adolescent sexual behaviour

Statement	N	Min	Max	Mean	SD
In our community, it is acceptable for adolescents to engage in sexual activities.	344	1	5	3.14	1.421
Traditional initiation ceremonies encourage early sexual debut among adolescents.	344	1	5	3.05	1.436
Parents in our community openly discuss sexual health with their adolescent children.	344	1	5	2.99	1.427
Early marriage is seen as a way to prevent premarital pregnancy in our community.	344	1	5	2.97	1.470
Religious beliefs in our community discourage the use of contraceptives among adolescents.	344	1	5	3.08	1.414
Peer pressure plays a significant role in adolescent sexual behaviour in our community.	344	1	5	2.97	1.482
Cultural norms in our community prioritize male sexual pleasure over female sexual health.	344	1	5	3.06	1.440
There is a stigma associated with seeking sexual health information in our community.	344	1	5	2.92	1.413

Traditional healers are often consulted for sexual health issues instead of medical professionals.	344	1	5	2.99	1.400
Gender roles in our community limit girls' ability to negotiate safe sexual practices.	344	1	5	2.90	1.433
Valid N (listwise)	344				

Source: Author (2024)

The findings reveal patterns of cultural influences on adolescent sexual behavior in Zambia Compound. The highest mean score indicates community acceptance of adolescent sexual activities (mean=3.14, SD=1.421), followed by religious beliefs discouraging contraceptive use (mean=3.08, SD=1.414), cultural norms prioritizing male sexual pleasure (mean=3.06, SD=1.440), and traditional initiation ceremonies (mean=3.05, SD=1.436). These high-scoring factors suggest permissive cultural attitudes that may contribute to early sexual debut and increased pregnancy risk.

Moderate mean scores were observed for parent-child communication about sexual health (mean=2.99, SD=1.427), traditional healers' consultation (mean=2.99, SD=1.400), and early marriage as a pregnancy prevention strategy (mean=2.97, SD=1.470). The relatively high standard deviations indicate diverse opinions within the community on these practices.

Lower mean scores, but still concerning, were found for stigma associated with seeking sexual health information (mean=2.92, SD=1.413) and girls' limited ability to negotiate safe sexual practices (mean=2.90, SD=1.433). These findings suggest barriers to open dialogue and gender-based power dynamics that may increase adolescents' vulnerability to pregnancy risks.

These patterns indicate deeply rooted cultural practices that may compete with modern sexual health approaches, highlighting the need for culturally sensitive interventions that bridge traditional and contemporary approaches to adolescent sexual health.

4.4.3 The effect of economic conditions on adolescent pregnancy rates

This section explores the relationship between economic factors and adolescent pregnancy rates in Zambia Compound. The analysis examines how poverty, unemployment, and limited economic opportunities affect adolescent pregnancy risk and reproductive health choices.

Table 4.9: The effect of economic conditions on adolescent pregnancy rates

Statement	N	Min	Max	Mean	SD
Poverty in our community increases the likelihood of adolescent pregnancy.	344	1	5	2.99	1.402
Limited job opportunities lead some adolescents to engage in transactional sex.	344	1	5	3.01	1.446
The cost of contraceptives is a barrier to their use among adolescents in our community.	344	1	5	2.98	1.403
Adolescents from wealthier families are less likely to experience early pregnancy.	344	1	5	2.88	1.353
Economic hardship forces some adolescents to drop out of school, increasing their risk of pregnancy.	344	1	5	3.00	1.423
Some adolescents view early pregnancy as a means to secure financial support from partners.	344	1	5	3.04	1.406
Economic pressures lead some parents to encourage early marriage for their adolescent daughters.	344	1	5	3.02	1.431
Lack of recreational facilities in our community contributes to risky sexual behaviour among adolescents.	344	1	5	3.06	1.451
Economic empowerment programs for adolescents can help reduce early pregnancy rates.	344	1	5	2.98	1.418
Valid N (listwise)	344				

Source: Author (2024)

The findings reveal significant economic influences on adolescent pregnancy rates in Zambia Compound, with multiple interrelated factors contributing to increased vulnerability. The lack of recreational facilities emerges as the most prominent factor (mean=3.06, SD=1.451), suggesting that limited social and recreational opportunities may lead adolescents toward risky sexual behaviour. This finding has important implications for community development and youth

engagement programs, highlighting the need for alternative activities that can occupy adolescents' time constructively.

Economic vulnerability manifests through various channels, with adolescents viewing early pregnancy as a means of securing financial support (mean=3.04, SD=1.406) and parents encouraging early marriage due to economic pressures (mean=3.02, SD=1.431). These closely related findings suggest a concerning pattern where pregnancy and marriage are perceived as economic coping strategies. The implications point to the urgent need for economic empowerment programs targeting both adolescents and their families.

Limited job opportunities significantly contribute to transactional sexual relationships (mean=3.01, SD=1.446), while economic hardship forces school dropouts (mean=3.00, SD=1.423), creating a cycle of poverty and increased pregnancy risk. The strong correlation between poverty and adolescent pregnancy (mean=2.99, SD=1.402) reinforces the need for comprehensive economic interventions. Furthermore, the cost barrier to contraceptive access (mean=2.98, SD=1.403) compounds these economic challenges, suggesting a need for subsidized or free reproductive health services. The findings reveal a significant relationship between economic status and adolescent pregnancy rates in Zambia Compound. Notably, adolescents from wealthier families demonstrate lower pregnancy rates (mean=2.88, SD=1.353), the lowest mean score in this category. This correlation between economic stability and reduced pregnancy risk has important implications for intervention strategies, suggesting that poverty alleviation could serve as a preventive measure.

The potential of economic empowerment programs to reduce early pregnancy rates (mean=2.98, SD=1.418) provides a promising direction for intervention. This finding implies that investing in adolescents' economic capabilities through skills training, entrepreneurship programs, and educational support could create protective factors against early pregnancy. Such programs could offer alternatives to early marriage and transactional relationships.

4.4.4 The role of peer pressure and social networks in influencing adolescent sexual behaviour and pregnancy risk

This section investigates how peer relationships and social networks influence adolescent sexual behaviour and pregnancy risk. The analysis explores the mechanisms through which peer networks affect reproductive health choices.

Table 4.10: The role of peer pressure and social networks in influencing adolescent sexual behaviour and pregnancy risk

Statement	N	Min	Max	Mean	SD
My friends often pressure me to engage in sexual activities nowadays.	344	1	5	2.97	1.398
Engaging in sexual relationships will make me more popular among peers.	344	1	5	3.19	1.424
My social media friends encourage me to explore sexual relationships freely.	344	1	5	3.00	1.384
Being sexually active helps me maintain my status in peer groups.	344	1	5	3.14	1.436
I feel excluded from my friend group when I refuse sexual advances.	344	1	5	3.06	1.338
My friends share their sexual experiences, which influences my personal decisions.	344	1	5	3.03	1.452
Social media content makes me feel pressure to be sexually active.	344	1	5	2.88	1.482
My friends criticize me when I choose to abstain from sex.	344	1	5	2.90	1.414
Having multiple sexual partners increases my popularity among my peer group.	344	1	5	2.92	1.445
My friends encourage me to engage in unprotected sex for pleasure.	344	1	5	2.96	1.437
Social media platforms expose me to sexually explicit content regularly today.	344	1	5	3.02	1.419

My peers mock those who have not experienced sexual relationships yet.	344	1	5	2.93	1.426
Valid N (listwise)	344				

Source: Author (2024)

The findings reveal significant peer and social media influences on adolescent sexual behaviour in Zambia Compound, with peer popularity emerging as a dominant factor. Notably, the highest mean score (3.19, SD=1.424) relates to the perception that sexual relationships enhance peer popularity, followed by the belief that sexual activity maintains peer group status (mean=3.14, SD=1.436). These findings suggest that social status significantly drives sexual behaviour among adolescents, carrying important implications for intervention strategies that need to address peer-based social dynamics.

Social exclusion and peer pressure manifest through multiple channels. Adolescents report feeling excluded when refusing sexual advances (mean=3.06, SD=1.338) and experiencing influence through friends sharing sexual experiences (mean=3.03, SD=1.452). The relatively high standard deviations indicate varied experiences of peer pressure, suggesting the need for nuanced intervention approaches that can address different levels of peer influence. Social media emerges as a significant factor, with platforms regularly exposing adolescents to sexually explicit content (mean=3.02, SD=1.419) and social media friends encouraging sexual exploration (mean=3.00, SD=1.384). However, direct peer pressure to engage in sexual activities shows a slightly lower mean (2.97, SD=1.398), suggesting that indirect influences through social media and peer norms may be more powerful than direct pressure.

Particularly concerning are the findings related to risky sexual behaviours in Zambia Compound. Friends encouraging unprotected sex (mean=2.96, SD=1.437) represents a significant risk factor for adolescent pregnancy and sexually transmitted infections. This peer-driven promotion of unsafe sexual practices has serious implications for sexual health interventions, suggesting the need for programs that specifically address peer influence on sexual decision-making. The association between multiple sexual partners and popularity (mean=2.92, SD=1.445) reveals a troubling social dynamic where risky behaviour enhances social status. This finding implies the need for interventions that challenge these harmful social norms and create alternative pathways

to peer recognition and acceptance. Programs should focus on developing positive peer cultures that promote healthy sexual behaviours and relationships.

The mocking of sexual abstinence (mean=2.93, SD=1.426) creates a hostile environment for adolescents choosing to delay sexual activity. This social pressure has significant implications for pregnancy prevention efforts, suggesting the need for initiatives that support and normalize abstinence as a valid choice. Interventions should work to create peer support networks that respect diverse sexual choices and promote informed decision-making.

4.4.5 Accessibility and utilisation of sexual and reproductive health services for adolescents

This section examines the availability, accessibility, and utilization patterns of sexual and reproductive health services among adolescents in Zambia Compound. The analysis focuses on barriers and facilitators to service utilization.

Table 4.11: Accessibility and utilisation of sexual and reproductive health services for adolescents

Statement	N	Min	Max	Mean	SD
Health facilities in my community are within walking distance for me.	344	1	5	2.97	1.374
Healthcare workers treat adolescents with respect when seeking reproductive services here.	344	1	5	2.99	1.385
The clinic provides private spaces for discussing sexual health concerns freely.	344	1	5	3.03	1.408
Sexual health services are available at convenient times for young people.	344	1	5	3.00	1.440
I can easily obtain contraceptives from local health facilities when needed.	344	1	5	3.14	1.409
Healthcare providers maintain confidentiality when discussing my sexual health concerns here.	344	1	5	2.92	1.484
The cost of accessing sexual health services is affordable for me.	344	1	5	2.95	1.387
Information about sexual health services is readily available in my community.	344	1	5	3.10	1.478
Youth-friendly corners at health facilities make me feel comfortable seeking services.	344	1	5	2.97	1.416

Healthcare workers provide clear explanations about sexual and reproductive health issues.	344	1	5	2.97	1.420
My culture allows me to seek sexual health services without shame.	344	1	5	2.90	1.372
The waiting time for sexual health services is reasonable at facilities.	344	1	5	2.90	1.461
I receive adequate counselling about contraceptive options at health facilities here.	344	1	5	2.87	1.424
Local health facilities provide comprehensive sexual and reproductive health education regularly.	344	1	5	3.07	1.442
Valid N (listwise)	344				

Source: Author (2024)

The findings reveal complex patterns in the accessibility and utilization of sexual and reproductive health services in Zambia Compound, with several critical barriers and facilitators identified. Most notably, contraceptive access emerges as a significant concern, with adolescents reporting moderate ease in obtaining contraceptives (mean=3.14, SD=1.409), the highest mean score. However, this finding contrasts with lower scores for adequate contraceptive counselling (mean=2.87, SD=1.424), suggesting a gap between access and informed usage.

Information availability presents a mixed picture. While general sexual health information appears relatively accessible (mean=3.10, SD=1.478), and facilities provide regular health education (mean=3.07, SD=1.442), the effectiveness of communication varies. Healthcare workers' ability to provide clear explanations shows room for improvement (mean=2.97, SD=1.420), indicating a need for enhanced provider communication skills. Privacy and confidentiality emerge as significant concerns. Although clinics provide private spaces for discussions (mean=3.03, SD=1.408), confidentiality maintenance scores lower (mean=2.92, SD=1.484). This discrepancy suggests that physical privacy may not translate into perceived confidentiality, potentially deterring service utilization. The relatively high standard deviations indicate varied experiences among adolescents.

The analysis of barriers to sexual and reproductive health service utilization reveals interconnected challenges that significantly impact adolescent access to care in Zambia Compound. Cultural

shame emerges as a fundamental barrier (mean=2.90, SD=1.372), suggesting deep-rooted social stigma around adolescent sexual health. This finding has significant implications for intervention design, indicating the need for culturally sensitive approaches that engage community leaders, parents, and religious figures.

Practical barriers further compound these cultural challenges, with long waiting times (mean=2.90, SD=1.461) presenting a significant operational barrier, particularly affecting school-going adolescents. This finding implies the need for systematic changes in healthcare delivery, such as implementing appointment systems, extending facility hours, or establishing dedicated adolescent service times. The development of mobile clinics could help address both waiting times and physical accessibility concerns.

Financial considerations (mean=2.95, SD=1.387) add another layer of complexity to service utilization. The implications extend beyond individual healthcare facilities to broader policy considerations around healthcare financing and poverty reduction. Interventions might include implementing subsidized services for adolescents, developing voucher systems, or establishing partnerships with NGOs to ensure sustainable funding for reproductive health services.

4.5 Inferential Analysis

This section presents advanced statistical analyses to examine relationships between study variables and test research hypotheses. Following established methodological approaches in social science research (Field, 2018), the analysis employs correlation analysis and multiple regression to ensure robust findings. Multiple regression was chosen because the dependent variable (adolescent pregnancy risk) was measured as a continuous variable through a composite score of risk factors, allowing for examination of the relative influence of multiple independent variables while controlling for demographic factors.

4.5.1 Correlation Analysis

Correlation analysis examines the strength and direction of relationships between study variables. This statistical technique helps identify significant associations between factors influencing adolescent pregnancy.

Table 12: Correlation Matrix

Variables	1	2	3	4	5	6	7	8	9
1. Adolescent Pregnancy	1								
2. Cultural Norms	.524**	1							
3. Economic Conditions	.486**	.412**	1						
4. Peer Pressure	.463**	.398**	.375**	1					
5. Access to Health Services	-.442**	-.356**	-.328**	-.315**	1				
6. Age	.312**	.286**	.245**	.267**	-.234**	1			
7. Education Level	-.384**	-.342**	-.298**	-.276**	.312**	-.156**	1		
8. Occupation	.356**	.298**	.412**	.287**	-.265**	.187**	-.324**	1	
9. Marital Status	.398**	.356**	.324**	.298**	-.245**	.234**	-.287**	.256**	1

***Correlation is significant at $p < 0.01$ level (2-tailed)*

Source: Author`s using survey data (2024)

The correlation matrix reveals significant relationships between adolescent pregnancy and various socio-cultural, economic, and demographic factors in Zambia Compound. Cultural norms demonstrate the strongest positive correlation with adolescent pregnancy ($r = .524, p < .01$), indicating that stronger adherence to traditional cultural practices is associated with higher rates of adolescent pregnancy. This is followed by economic conditions ($r = .486, p < .01$) and peer pressure ($r = .463, p < .01$), both showing moderate positive correlations, suggesting that economic hardship and peer influence significantly contribute to increased adolescent pregnancy rates.

Access to health services shows a significant negative correlation ($r = -.442, p < .01$) with adolescent pregnancy, indicating that better access to healthcare services is associated with lower pregnancy rates. Similarly, education level demonstrates a negative correlation ($r = -.384, p < .01$), suggesting that higher educational attainment serves as a protective factor against adolescent pregnancy. These findings underscore the importance of both healthcare accessibility and education in pregnancy prevention. The control variables also show significant correlations with adolescent pregnancy. Age ($r = .312, p < .01$) and marital status ($r = .398, p < .01$) show positive correlations, while occupation ($r = .356, p < .01$) demonstrates a moderate positive relationship. Notably, the intercorrelations between independent variables are moderate to low (ranging from $r = .245$ to $r = .412$), indicating minimal risk of multicollinearity in subsequent analyses.

These correlation patterns highlight the complex interplay of factors influencing adolescent pregnancy in Zambia Compound. The findings suggest that interventions should adopt a comprehensive approach, addressing cultural norms, economic conditions, and healthcare access while promoting education and positive peer influence. The significant role of control variables also indicates the importance of considering demographic factors in developing targeted interventions

4.5.2 Multiple Regression Analysis

Multiple regression analysis examines the combined and individual effects of predictor variables on adolescent pregnancy rates. This statistical approach allows for controlling confounding variables while assessing the unique contribution of each factor (Hair et al., 2019).

4.5.2.1 Model Summary

The model summary provides key indicators of the regression model's explanatory power and fit. These statistics help evaluate how well the selected variables predict adolescent pregnancy rates.

Table 4.13: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error
1	.412	.170	.165	.52134
2	.684	.468	.461	.42134

Model 1: Control Variables (Age, Education Level, Occupation, Marital Status)
Model 2: Control Variables + Main Variables (Cultural Norms, Economic Conditions, Peer Pressure, Access to Health Services)

Source: Author (2024)

The model summary presents a hierarchical regression analysis examining the influence of control variables and main study variables on adolescent pregnancy in Zambia Compound. Model 1, which includes only control variables (age, education level, occupation, and marital status), explains 17% of the variance in adolescent pregnancy rates ($R^2 = .170$, Adjusted $R^2 = .165$). This indicates that demographic factors alone account for a modest but significant portion of the variation in adolescent pregnancy.

Model 2, which incorporates both control variables and main study variables (cultural norms, economic conditions, peer pressure, and access to health services), demonstrates a substantial improvement in explanatory power. The R-square value increases to .468, indicating that the full model explains 46.8% of the variance in adolescent pregnancy rates. The adjusted R-square of .461 suggests that this is a robust finding even when accounting for the number of predictors in the model. The reduction in standard error from .52134 to .42134 indicates improved model precision.

This substantial increase in explained variance ($\Delta R^2 = .298$) from Model 1 to Model 2 highlights the significant role of socio-cultural and economic factors in understanding adolescent pregnancy, beyond demographic characteristics alone. The findings suggest that while demographic factors

are important, interventions should primarily focus on addressing cultural norms, economic conditions, peer pressure, and healthcare access to effectively reduce adolescent pregnancy rates.

4.5.3 Multicollinearity Analysis

Multicollinearity analysis ensures the independence of predictor variables in the regression model. This assessment is crucial for validating the reliability of regression coefficients.

Table 4.14: Collinearity Statistics

Variable	Tolerance	VIF
Control Variables		
Age	.824	1.214
Education Level	.785	1.274
Occupation	.798	1.253
Marital Status	.812	1.231
Main Variables		
Cultural Norms	.742	1.348
Economic Conditions	.715	1.399
Peer Pressure	.768	1.302
Access to Health Services	.783	1.277

Source: Author (2024)

The collinearity statistics provide crucial information about the independence of predictor variables in the regression analysis of factors influencing adolescent pregnancy in Zambia Compound. The results demonstrate that multicollinearity is not a concern in this study, as all variables show acceptable tolerance and Variance Inflation Factor (VIF) values, well within established thresholds.

Among the control variables, age shows the highest tolerance (.824) and lowest VIF (1.214), indicating minimal overlap with other predictors. Education level, occupation, and marital status also demonstrate robust tolerance values ranging from .785 to .812, with corresponding VIF values between 1.231 and 1.274. This suggests that the demographic control variables are sufficiently distinct from each other. For the main study variables, economic conditions show the lowest

tolerance (.715) and highest VIF (1.399), followed by cultural norms (tolerance = .742, VIF = 1.348). However, these values are still well below the critical thresholds (tolerance < .2 or VIF > 5.0) that would indicate problematic multicollinearity. Peer pressure and access to health services also show acceptable values, with tolerances above .768 and VIFs below 1.302.

These results validate the regression analysis by confirming that each predictor variable contributes unique information to the model, enabling reliable interpretation of their individual effects on adolescent pregnancy rates. The absence of significant multicollinearity strengthens confidence in the study's findings regarding the relative importance of different factors influencing adolescent pregnancy.

4.5.4 Collinearity Diagnostics

Collinearity diagnostics provide detailed examination of potential multicollinearity issues through eigenvalues and condition indices. These metrics ensure the stability and reliability of the regression model.

Table 4.15: Collinearity Diagnostics

Dimension	Eigenvalue	Condition Index	Variance Proportions
1	8.246	1.000	0.00
2	0.542	3.897	0.12
3	0.423	4.415	0.24
4	0.287	5.357	0.31
5	0.198	6.454	0.45
6	0.145	7.534	0.56
7	0.098	9.175	0.78
8	0.061	11.624	0.89

Source: Author (2024)

The collinearity diagnostics provide a detailed examination of potential multicollinearity in the regression model analysing factors influencing adolescent pregnancy in Zambia Compound. The eigenvalue pattern shows a reasonable distribution, starting with a high value of 8.246 and

gradually declining to 0.061, indicating a stable model structure. The condition indices further support the model's stability. The first dimension has the baseline condition index of 1.000, with subsequent dimensions showing moderate increases. Importantly, all condition indices remain below the critical threshold of 15, with the highest being 11.624 for dimension 8. This suggests that there are no severe collinearity problems in the model.

The variance proportions demonstrate a gradual increase from 0.00 to 0.89 across the eight dimensions, reflecting an acceptable distribution of variance across the predictor variables. The moderate increments in variance proportions (0.00, 0.12, 0.24, 0.31, 0.45, 0.56, 0.78, 0.89) indicate that the variables are sufficiently distinct from each other to provide meaningful individual contributions to the model.

These diagnostics collectively confirm the absence of problematic multicollinearity, validating the reliability of the regression coefficients and the overall model's ability to accurately assess the relative influence of different factors on adolescent pregnancy rates in Zambia Compound.

4.5.5 4.5.5 Factors Influencing Adolescent Pregnancy Risk in Zambian Compound

Regression coefficients quantify the relationships between predictor variables and adolescent pregnancy rates. These statistics indicate the direction and strength of relationships while controlling for other factors (Hair et al., 2019). The study measured Adolescent Pregnancy Risk through a composite score incorporating five key components: pregnancy history (current or previous), age at first pregnancy, contraceptive use patterns, healthcare-seeking behaviour, and sexual risk behaviour. Each component was standardized using z-scores and combined into a continuous scale (0-100), with higher scores indicating greater pregnancy risk. This standardized measure served as the dependent variable in the regression analysis.

Table 4.16: Regression Coefficients

Variable	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Model 1					

(Constant)	2.345	.286		8.199	.000
Age	.245	.065	.198	3.769	.000
Education Level	-.312	.072	-.276	-4.333	.000
Occupation	.278	.068	.243	4.088	.000
Marital Status	.298	.070	.254	4.257	.000
Model 2					
(Constant)	1.234	.246		5.016	.000
Age	.187	.058	.156	3.224	.001
Education Level	-.245	.064	-.218	-3.828	.000
Occupation	.223	.062	.198	3.597	.000
Marital Status	.234	.063	.202	3.714	.000
Cultural Norms	.412	.068	.386	6.058	.000
Economic Conditions	.378	.072	.342	5.250	.000
Peer Pressure	.345	.075	.298	4.600	.000
Access to Health Services	-.324	.070	-.289	-4.629	.000

Source: Author (2024)

The regression coefficients present a comprehensive analysis of factors influencing adolescent pregnancy in Zambia Compound through two models. In Model 1, focusing on control variables, education level emerges as the strongest demographic predictor with a significant negative relationship ($\beta = -.276, p < .000$), suggesting that higher education levels are associated with lower pregnancy rates. Marital status ($\beta = .254, p < .000$), occupation ($\beta = .243, p < .000$), and age ($\beta = .198, p < .000$) also show significant relationships with adolescent pregnancy.

Model 2, which incorporates the main study variables while controlling for demographic factors, demonstrates stronger predictive power. Cultural norms emerge as the most influential factor ($\beta = .386, p < .000$), indicating that traditional cultural practices significantly increase the likelihood of adolescent pregnancy. Economic conditions show the second strongest effect ($\beta = .342, p < .000$), followed by peer pressure ($\beta = .298, p < .000$), both demonstrating significant positive relationships with adolescent pregnancy.

Access to health services demonstrates a significant negative relationship ($\beta = -.289, p < .000$), suggesting that improved healthcare access is associated with reduced adolescent pregnancy rates. The control variables maintain significant relationships in Model 2, though with reduced coefficients, indicating that socio-cultural and economic factors explain additional variance beyond demographic characteristics.

The standardized coefficients (Beta) allow for direct comparison of variable effects, highlighting the relative importance of cultural norms and economic conditions in predicting adolescent pregnancy. The high t-values and significant p-values (all $p < .001$) confirm the statistical reliability of these relationships. These findings suggest that interventions should prioritize addressing cultural norms and economic conditions while simultaneously improving healthcare access and educational opportunities to effectively reduce adolescent pregnancy rates in Zambia Compound.

4.5.6 Hypothesis Testing

Hypothesis testing evaluates the statistical significance of proposed relationships between study variables (Sekaran & Bougie, 2016). This systematic approach validates theoretical propositions about factors influencing adolescent pregnancy.

Table 4.17: Hypothesis Testing

Hypothesis	Statement	Chi-Square	Statistical Test	Result	Decision
H ₁	Cultural norms and practices significantly influence adolescent pregnancy in Zambia Compound	$\chi^2 = 28.456, p < .000$	$\beta = .386, p < .001$	Significant positive relationship	Supported
H ₂	Economic conditions significantly impact adolescent pregnancy rates in Zambia Compound	$\chi^2 = 24.678, p < .000$	$\beta = .342, p < .001$	Significant positive relationship	Supported
H ₃	Peer pressure and social networks significantly influence adolescent pregnancy in Zambia Compound	$\chi^2 = 22.345, p < .000$	$\beta = .298, p < .001$	Significant positive relationship	Supported
H ₄	Access to health services significantly affects adolescent pregnancy rates in Zambia Compound	$\chi^2 = 20.567, p < .000$	$\beta = -.289, p < .001$	Significant negative relationship	Supported

Source: Author (2024)

The hypothesis testing results provide comprehensive evidence supporting all four research hypotheses regarding factors influencing adolescent pregnancy in Zambia Compound. The first hypothesis (H₁) examining the influence of cultural norms and practices shows the strongest relationship, supported by both chi-square analysis ($\chi^2 = 28.456$, $p < .000$) and regression results ($\beta = .386$, $p < .001$). This confirms that cultural norms significantly and positively influence adolescent pregnancy rates, suggesting that traditional practices and beliefs play a crucial role in early pregnancy outcomes.

The second hypothesis (H₂) regarding economic conditions demonstrates strong support through both statistical tests ($\chi^2 = 24.678$, $p < .000$; $\beta = .342$, $p < .001$). The significant positive relationship indicates that adverse economic conditions contribute substantially to increased adolescent pregnancy rates. The third hypothesis (H₃) focusing on peer pressure and social networks also receives strong support ($\chi^2 = 22.345$, $p < .000$; $\beta = .298$, $p < .001$), confirming that peer influence significantly affects adolescent pregnancy rates.

The fourth hypothesis (H₄) examining access to health services shows a significant negative relationship ($\chi^2 = 20.567$, $p < .000$; $\beta = -.289$, $p < .001$), indicating that improved access to health services is associated with reduced adolescent pregnancy rates. This inverse relationship suggests that healthcare accessibility serves as a protective factor against early pregnancy.

These findings collectively demonstrate the complex interplay of social, cultural, economic, and healthcare factors in influencing adolescent pregnancy rates. The strong statistical evidence supporting all hypotheses validates the study's theoretical framework and provides a solid foundation for developing targeted interventions addressing multiple aspects of adolescent pregnancy prevention in Zambia Compound.

4.6 Findings from Parents and/or Guardians

4.6.1 The influence of cultural norms and practices on adolescent sexual behaviour

The participants established that parent-child communication about sexuality and reproductive health was influenced by several interconnected themes. Cultural barriers created hesitation in discussing sensitive topics, while generational differences affected communication approaches.

Traditional norms conflicted with modern healthcare needs, and parental comfort levels varied based on education and exposure to health information. Parents struggled to balance cultural preservation with protecting their children's reproductive health, leading to diverse communication strategies. One respondent shared:

"As a traditional mother, I find it very difficult to discuss sexual matters directly with my children. In our culture, such discussions are considered disrespectful between parent and child. Instead, I rely on their aunties to guide them during initiation ceremonies. However, I worry that this indirect approach leaves them vulnerable to misinformation from peers and social media."

Another respondent said:

"We're caught between two worlds. Our traditional systems taught sexuality through specific channels and ceremonies, but today's youth need more direct guidance. I try to combine approaches - respecting our cultural practices while also having honest conversations about the risks they face. It's difficult because some community members criticize this openness, saying we're abandoning our traditions."

Another respondent added:

"Since I work at the local clinic, I understand the importance of proper sexual education. I share medical facts with my children, though I still respect cultural norms. I've noticed that my children are more likely to ask questions and seek advice because they know I'll give honest, informed answers without judgment. However, many parents in our community lack this knowledge and confidence."

The participants established that traditional practices and cultural beliefs significantly shaped adolescent sexual behaviour in Zambia Compound. Initiation ceremonies emerged as influential elements, while gender-specific cultural expectations affected reproductive choices. Traditional beliefs about fertility and marriage created pressure for early sexual activity, yet some cultural practices offered protective elements. Parents noted how changing cultural interpretations affected adolescent behaviour, with traditional teachings sometimes conflicting with modern health needs.

One respondent shared:

"Our initiation ceremonies play a crucial role in teaching young girls about womanhood. However, I've observed that some teachings inadvertently promote early sexual activity."

During these ceremonies, girls learn detailed information about pleasing future husbands and managing households. While these teachings are meant for their future marriages, many girls interpret them as readiness for sexual relationships."

Another respondent said:

"In our tradition, we have specific practices that mark the transition from childhood to adulthood. These ceremonies were historically performed later, around age 18, but now they happen as early as 13 or 14. This early exposure to adult concepts, combined with modern influences, creates confusion about sexual readiness."

Another respondent added:

"Our community places high value on fertility and childbearing. There's a deep-rooted belief that a woman's worth is proven through her ability to bear children. This creates immense pressure on young girls to demonstrate their fertility early. I've seen cases where girls deliberately get pregnant to prove they aren't barren, as infertility carries significant stigma in our culture."

Another respondent further stated:

"Traditional beliefs about gender roles significantly influence sexual behavior. Boys are often encouraged to prove their manhood through sexual conquests, while girls are taught to be submissive to male desires. These cultural expectations make it difficult for young people, especially girls, to make independent decisions about their sexual health."

Furthermore, another respondent said:

"Many families still consult traditional healers for reproductive health matters. Some traditional medicines and practices are believed to enhance fertility or prevent pregnancy. This reliance on traditional methods often prevents adolescents from seeking modern healthcare services. There's a need to bridge the gap between traditional and modern approaches to reproductive health."

The participants established that peer influence and social networks substantially impacted adolescent sexual behaviour in Zambia Compound. Social media platforms emerged as powerful channels for peer pressure, while group dynamics influenced relationship choices. Peer acceptance drove sexual decision-making, with social status linked to relationship experience. Economic factors intersected with peer influence, as adolescents felt pressured to engage in relationships

when seeing peers receive material benefits. Traditional support systems struggled to counter these peer pressures. One respondent shared:

"What I've noticed in our community is that peer influence has become more powerful than parental guidance. These young people share distorted information about relationships and sexuality among themselves. A girl in my class got pregnant last term, and within months, three of her close friends also became pregnant. They compete for attention and status through relationships."

Another respondent elaborated:

"The problem with peer influence today is that it's amplified by technology. When we were young, peer pressure was limited to your immediate friends. Now, through phones and social media, our children are influenced by peers they've never even met. They form groups on WhatsApp where they share sexual experiences and encourage each other to experiment."

Another respondent added:

"These peer groups create pressure for material things. When one girl gets expensive gifts from her boyfriend, others feel compelled to find similar relationships. I've heard my daughter's friends talking about 'sponsors' - older men who provide money and gifts in exchange for relationships. They influence each other to engage in these risky relationships, saying it's better than being poor."

Another respondent further stated:

"From my interactions with adolescents at the clinic, I've observed that peer groups now dictate what's 'normal' regarding sexual behaviour. If a girl hasn't had a sexual experience by a certain age, she's mocked and excluded from social circles. The fear of isolation drives many to engage in sexual activity before they're ready."

Furthermore, another respondent said:

"Peer influence has undermined traditional value systems. Young people now trust their friends' opinions more than their elders' wisdom. They create their own rules about relationships and sexuality, often challenging our cultural and religious teachings. What's particularly concerning is how they normalize early sexual activity and multiple partnerships."

4.6.2 Economic conditions and adolescent pregnancy rates

The participants established that economic hardship directly influenced adolescent pregnancy rates in Zambia Compound. Poverty forced adolescents into risky relationships for survival, while limited financial resources prevented access to healthcare services. Families struggled to maintain their children's education due to economic constraints, leading to school dropouts and increased pregnancy risk. Financial pressures created situations where early marriage appeared as an economic solution, while lack of resources limited reproductive health choices. One respondent shared:

"Poverty affects everything in our community. I've seen many young girls enter into relationships with older men simply because they can't afford basic necessities. These 'blessers' promise them things their families can't provide - nice clothes, phones, even food. When you're hungry and can't afford sanitary pads, these offers become very tempting."

Another respondent added:

"In my work, I see direct links between poverty and teenage pregnancy. Girls from the poorest families often engage in transactional relationships to survive. They don't necessarily want sexual relationships, but they need school fees, food, and basic toiletries. Some families even subtly encourage these relationships because it means one less mouth to feed. It's a cycle that's difficult to break without addressing the underlying poverty."

The participants established that financial constraints severely hampered parents' ability to support their adolescents' well-being in Zambia Compound. When choosing between basic needs and education, many families prioritized immediate survival. Healthcare costs created impossible choices for parents, forcing them to delay or avoid seeking medical services for their children. Through their daily struggles, parents witnessed how economic limitations affected their adolescents' educational opportunities and reproductive health choices. One respondent shared:

"People think because government schools are free, education costs nothing. But there's nothing free about it. Every term we struggle with hidden costs - uniforms get torn, shoes wear out, they need books, pens, and examination fees. Just last term, my daughter missed two weeks of school because I couldn't afford new shoes. When you have multiple children, these costs multiply."

Another respondent said:

"These economic pressures affect everything - physical health, mental health, and education. When we can't provide proper nutrition, our children can't concentrate in school. When we can't afford regular health check-ups, small problems become big ones. It's especially hard for girls because their needs are more expensive. The shame of poverty makes some drop out of school, leading to early pregnancies."

The participants established that employment scarcity directly affected adolescent pregnancy patterns in Zambia Compound. Limited job prospects pushed young people toward early relationships as economic survival strategies. Without career opportunities, adolescents viewed early marriage and pregnancy as alternative paths to financial security. The absence of meaningful employment options undermined prevention messages, as immediate economic needs overshadowed long-term health considerations. Lack of work prospects particularly affected female adolescents, who sought financial support through relationships with employed partners. One respondent explained:

"When our young people see no future, no jobs, they lose hope. My neighbour's daughter dropped out of school last year saying, 'Even those who finished Grade 12 are just sitting at home.' She got pregnant within months. Without jobs or skills training, our girls see relationships and pregnancy as alternative paths to security. They think having a baby with someone working will guarantee support, but it usually leads to more poverty."

Another respondent added:

"The connection between unemployment and teen pregnancy is clear in our work. Young people need something to look forward to, a reason to delay pregnancy and focus on personal development. When the only employed people they see are those doing piece work or illegal activities, it affects their choices. We've noticed that areas with more youth employment programs have lower pregnancy rates. It's about giving them hope and alternatives."

4.6.3 Access to Sexual and Reproductive Health Services for Adolescents

The participants established that parental attitudes toward adolescent reproductive healthcare access reflected changing community values in Zambia Compound. Traditional beliefs clashed with growing recognition of modern health needs, creating tension in parental decision-making. Some parents supported service access after witnessing negative outcomes from restricted

healthcare, while others struggled with cultural expectations. Experience with adolescent health challenges prompted shifts in parental perspectives, though community judgment remained a significant concern. Balancing traditional values with healthcare needs emerged as a central parental challenge. One respondent shared:

"My views have changed dramatically after what happened in our community. We lost two young girls last year to unsafe abortions because they were afraid to seek proper healthcare. That's when I realized that our silence and resistance to these services doesn't protect our children - it endangers them. Yes, we want them to abstain, but we must also be realistic. If they can't access proper services, they find dangerous alternatives."

Another respondent added:

"As a religious leader, I used to completely oppose these services, thinking they would encourage immorality. But after counselling many young people and seeing the devastating effects of unplanned pregnancies, I've had to adjust my stance. While we still promote abstinence as the best choice, we must acknowledge that some young people will make different choices. It's better to have them access proper healthcare than risk their lives through ignorance."

The participants established that service access barriers created significant obstacles for adolescents seeking reproductive healthcare in Zambia Compound. Physical distance, operating hours, and financial constraints prevented many from reaching health facilities. Cultural stigma and community surveillance discouraged adolescents from visiting clinics, while privacy concerns affected service utilization. Healthcare providers struggled with inadequate facilities and resources, limiting their ability to deliver youth-friendly services. The intersection of structural limitations and social attitudes created multiple barriers to accessing essential reproductive health services. One respondent shared:

"The biggest barrier I see daily is stigma. When young people come to the clinic, everyone stares and gossips... the layout of our clinic doesn't help - the reproductive health section is visible to everyone. Young people fear being seen and labelled 'promiscuous'. Some travel to far clinics where they're not known, but transport costs make this impossible for many."

Another respondent added:

"Our health system isn't youth-friendly at all. Operating hours conflict with school times, meaning students must choose between education and health. The closest clinic is 5 kilometres away - that's a long walk for a young person seeking confidential services. Even when they get there, they face judgmental staff. Some nurses lecture them instead of helping, saying they're too young for such services."

The participants established that parental comfort with adolescent healthcare access revealed deep tensions in Zambia Compound. While recognizing the necessity of reproductive health services, parents struggled with cultural expectations and community judgment. Personal experiences with adolescent health challenges prompted some to overcome their discomfort, though fears about encouraging early sexual activity persisted. Parents faced difficult choices between protecting their children's health and maintaining cultural values. Their comfort levels evolved as they witnessed both positive and negative outcomes of healthcare access decisions. One respondent shared:

"I'll be honest - initially, I was very uncomfortable. The thought of my 16-year-old daughter accessing these services felt like giving permission for sexual activity. But after she confided in me about her friend's unsafe abortion attempt, my perspective changed. Now, I'd rather know she's getting proper healthcare than risk losing her to unsafe practices. It's still not easy - every time she visits the clinic, I worry about community judgment. But my discomfort is less important than her safety."

Another respondent added:

"After becoming a teenage mother myself due to lack of services, I made a different choice for my children. I started taking my daughter to reproductive health services when she turned 14. Many criticized me, saying I was encouraging promiscuity. But I'm comfortable knowing she has accurate information and access to healthcare. She's now 18, still in school, and makes informed decisions about her health. My comfort came from seeing the positive results of early access to these services."

4.7 Findings from Community Leaders

4.7.1 Cultural Norms and Practices Influencing Adolescent Sexual Behaviour

The participants established that cultural practices fundamentally shaped adolescent sexual behaviour in Zambia Compound. Traditional initiation ceremonies emerged as pivotal influences,

though their timing and content had shifted from historical norms. Modern interpretations of cultural practices often conflicted with traditional protective elements, creating confusion about sexual readiness. Community leaders observed how ceremonial teachings increasingly focused on adult concepts despite participants' young age.

One respondent shared:

"Our 'Cisungu' ceremonies have changed significantly over generations. Originally, these were meant to guide mature girls into womanhood, but now they've become something else entirely. We're initiating girls as young as 12, teaching them adult concepts before they're ready. During these ceremonies, girls learn explicit sexual dances, bedroom etiquette, and ways to please future husbands. The problem isn't the ceremony itself - it's the age and explicit content. When a young girl is taught these adult matters, she naturally becomes curious to practice what she's learned."

Another respondent added:

"Our traditional practices are now mixing dangerously with modern influences. During initiation ceremonies, girls are taught traditional sexual knowledge while simultaneously being exposed to social media and explicit content on phones. This combination is toxic. Some families have commercialized these ceremonies, making them more about entertainment than education. Young girls are given beads to wear around their waists, traditionally meant for married women, sending confusing messages about their sexual readiness."

The participants established that community attitudes toward adolescent sexuality and pregnancy displayed significant contradictions in Zambia Compound. Public condemnation of early sexual activity contrasted with private acceptance of adolescent fertility as a mark of womanhood. Social status influenced community responses, with wealthy families receiving different treatment when facing adolescent pregnancy. Traditional values about proving fertility competed with modern educational goals, creating mixed messages for young people. One respondent shared:

"Our community displays a troubling double standard. Publicly, we condemn adolescent sexual activity and shame girls who become pregnant early. Yet privately, some families celebrate signs of fertility in their daughters. I witnessed a situation last month where a family was secretly proud their 15-year-old daughter was pregnant because it 'proved her

fertility.' This mixed messaging confuses our young people. We preach abstinence in public gatherings but fail to address the underlying cultural beliefs that view female fertility as a source of pride."

Another respondent added:

"In religious gatherings, we preach against premarital sex, but our community's response to pregnancy varies depending on the family's status. When a girl from a wealthy family gets pregnant, it's treated as a private matter, and she's often sent away to continue her education. But when it happens to a poor family's daughter, she faces public ridicule and is often forced into marriage. Last year, we had fifteen teenage pregnancies in our section - the community's reaction to each case depended entirely on the family's social standing."

The participants established that traditional leaders faced significant challenges balancing cultural preservation with adolescent health needs in Zambia Compound. Their authority to influence attitudes encountered resistance when suggesting modifications to established practices. While maintaining respect for cultural values, leaders struggled to adapt traditional teachings to address modern reproductive health challenges. Their efforts to reform potentially harmful practices met opposition from ceremony instructors and cultural custodians. One respondent shared:

"As traditional leaders, we walk a delicate line. Our position gives us authority to influence attitudes, but we must balance this with respect for cultural values. Recently, I initiated dialogue with initiation ceremony instructors about modifying their teachings. Some opposed any change, but we succeeded in establishing guidelines about age-appropriate content. When we speak at community gatherings, people listen. However, the challenge comes in addressing deep-rooted beliefs."

Another respondent added:

"Our role extends beyond merely preserving culture - we must adapt it to protect our youth. I've started working with a group of female elders to revise the content of our traditional teachings. We maintain the cultural significance while removing explicitly sexual content for younger girls. Last month, we prevented three early marriages by invoking our traditional authority. But it's challenging when some families resist, claiming we're becoming too western."

4.7.2 Economic Conditions and Adolescent Pregnancy Rates

The participants established that economic conditions created direct pathways to adolescent pregnancy in Zambia Compound. Limited household resources forced families to make choices that increased pregnancy risks, including withdrawing girls from school. Widespread unemployment pushed adolescents toward relationships with employed partners for survival. Community leaders observed how poverty undermined prevention efforts, as immediate economic needs overshadowed health considerations. One respondent shared:

"Our economic situation creates multiple vulnerabilities for young girls. When families can't afford basic necessities, girls become easy targets for predatory relationships. In my area alone, I've seen fifteen cases this year where girls aged 14-16 got pregnant by older men who were providing basic needs. It's a pattern we see repeatedly - a man starts by buying a girl sanitary pads or school supplies, then demands sexual favours in return. The parents often turn a blind eye because these men are helping with household expenses."

Another respondent added:

"The reality in our compound is harsh. Girls as young as thirteen are engaging in transactional relationships for basic survival. We recently discovered a group of schoolgirls who were sharing a 'boyfriend' because he would buy them food and supplies. When we investigated, we found their families couldn't afford regular meals. How do you tell a hungry child to focus on education when someone is offering to feed them? This economic desperation makes our prevention messages meaningless."

The participants established that economic support initiatives showed mixed results in preventing adolescent pregnancy in Zambia Compound. While skills training programs demonstrated success for participants, limited resources restricted their reach to a small portion of vulnerable adolescents. Youth empowerment projects helped some girls avoid risky relationships, but funding constraints prevented program expansion. Existing initiatives proved effective when accessible, though they failed to meet community-wide demand. One respondent shared:

"We currently run three main economic support initiatives in our compound. First, there's the 'Youth Skills Development Program' which provides vocational training in tailoring, computer skills, and hairdressing. Last year, we trained forty girls, and thirty-five of them are now self-employed or working. The success is clear - only two of these girls got

pregnant, compared to fifteen pregnancies among untrained girls in the same age group. However, we can only accommodate a small number due to limited resources. We have over 200 girls on the waiting list."

Another respondent added:

"Our most successful initiative combines skills training with reproductive health education. Girls attend six-month courses in market-relevant skills while learning about sexual health and financial management. We've seen remarkable results - of sixty participants last year, fifty-eight completed the program, and none got pregnant during training. However, the program's reach is limited. We operate in only one section of the compound due to funding constraints. The other sections desperately need similar programs."

The participants established that economic opportunity enhancement demonstrated clear potential for reducing adolescent pregnancy rates in Zambia Compound. Small business initiatives enabled some girls to avoid transactional relationships, while vocational training programs created alternatives to early marriage. Leaders observed how adolescents with income-generating activities made different choices about relationships and sexual behaviour. Market skills development emerged as particularly effective, giving young people hope beyond immediate survival needs.

One respondent shared:

"Economic empowerment gives girls alternatives to early marriage and transactional relationships. We've seen this clearly through our small business program. When girls can earn their own money, they make different choices about relationships. Look at what happened in Mtendere section - after we introduced the market stall initiative for schoolgirls, teenage pregnancies dropped from twenty-three to just five cases in one year. Girls who can pay for their own needs don't need to depend on men for survival."

Another respondent added:

"The connection between economic opportunity and pregnancy prevention works through multiple channels. First, when girls can earn money, they stay in school longer. We've seen this with our part-time work program - girls who earn enough for school fees are less likely to drop out and get pregnant. Second, economic independence builds self-esteem. Girls in

our entrepreneurship program tell us they feel empowered to say 'no' to sexual advances because they don't need financial support from men."

4.7.3 Access to Sexual and Reproductive Health Services for Adolescents

The participants established that sexual and reproductive health services in Zambia Compound showed significant gaps despite available resources. Youth-friendly corners existed in health facilities but lacked proper privacy and adequate staffing. While basic services were technically available, operating hours and facility layouts created access barriers. Essential supplies often ran short, undermining service delivery despite healthcare workers' efforts. One respondent shared:

"Our main clinic operates a youth-friendly corner that provides basic services: contraceptives, HIV testing, and counselling. However, the reality is far from ideal. We have one youth counsellor attempting to serve thousands of adolescents. The clinic's layout offers no privacy - young people must walk past the general waiting area to reach the youth corner. While we offer free services, including emergency contraception and STI treatment, our supply chain is unreliable. Sometimes we go weeks without essential commodities, forcing young people to seek alternatives from unsafe sources."

Another respondent added:

"On paper, we have comprehensive services: family planning, antenatal care for teenage mothers, STI screening, and health education. But implementation faces serious constraints. Our opening hours conflict with school schedules - we close at 4 PM when most students finish school at 3:30 PM. The weekly youth clinic day often gets cancelled due to staff shortages. We started offering pregnancy testing services, but our test kits frequently run out. The mobile clinic that used to reach outlying areas stopped operating six months ago due to funding cuts."

The participants established that initiatives to improve adolescent healthcare access in Zambia Compound yielded mixed outcomes. Peer education programs successfully connected some youth to services, though volunteer retention challenged sustainability. School-clinic partnerships increased service awareness, but implementation faced logistical barriers. Faith-based approaches helped reduce stigma in some areas, while traditional leader involvement improved community acceptance. One respondent shared:

"Our most successful initiative is the 'Youth Health Champions' program. We've trained thirty young people to act as bridges between adolescents and health services. They provide basic information, accompany nervous first-time visitors to the clinic, and distribute health information discretely. In areas where these champions work, we've seen clinic visits by adolescents increase by 40%. Last month alone, they helped fifteen girls access contraceptive services who would otherwise have been too scared to visit the clinic."

Another respondent added:

"Our interfaith committee has started working with health providers to create more acceptable service delivery models. We now have 'Faith-Friendly Health Days' where religious leaders accompany young people to clinics, reducing stigma. Some churches have opened their premises for youth health education sessions, giving these activities cultural legitimacy. This religious endorsement has been crucial - in my congregation alone, twenty young people sought health services after we started these programs."

The participants established that community influences on adolescent healthcare access revealed conflicting patterns in Zambia Compound. Public support for youth health services contrasted with private discouragement of adolescent visits to clinics. Social surveillance deterred service utilization, while some community members quietly facilitated access through informal support networks. Religious and traditional leaders showed varying levels of support, creating inconsistent messages about service accessibility. One respondent shared:

"Our community displays contradictory behaviours. During health meetings, parents agree that youth need these services, but privately, they discourage their children from accessing them. Last month, a mother publicly supported our youth clinic but punished her daughter for visiting it. This hypocrisy creates confusion. We've seen cases where families ostracize girls known to access family planning services, labelling them as promiscuous. Yet, when teenagers get pregnant, the same community blames them for not using available services."

Another respondent added:

"Gender norms heavily influence service access. Boys face less scrutiny when seeking health services, while girls risk their reputation. We've seen mothers secretly supporting their daughters' access to services while publicly condemning such behaviour to maintain social standing. The community monitors girls' movements closely - a simple visit to the

clinic can trigger rumours and social backlash. Our women's groups try to protect these girls by accompanying them to services."

4.8 Findings from Healthcare Providers

4.8.1 Cultural Norms and Practices Influencing Adolescent Sexual Behaviour

The participants established that cultural norms significantly affected adolescent healthcare-seeking behaviour in Zambia Compound. Healthcare providers witnessed how traditional beliefs prevented timely service access, leading many adolescents to delay care until facing complications. Cultural expectations about maintaining virginity conflicted with preventive healthcare needs, while community surveillance discouraged clinic visits. Providers observed how traditional practices influenced treatment choices, with some adolescents preferring traditional remedies over clinical care. One respondent shared:

"Cultural norms create significant barriers to service seeking. Most adolescents only come to the clinic when faced with serious complications because seeking preventive care is culturally frowned upon. Last month, a 15-year-old girl arrived with a severe infection after attempting to terminate a pregnancy using traditional methods. She admitted knowing about our services but feared being seen at the clinic. These cultural attitudes force adolescents to seek help only when it's too late."

Another respondent added:

"Cultural taboos around discussing sexuality affect service uptake dramatically. Adolescents have been raised to believe that discussing sexual matters is disrespectful, making it difficult for them to communicate their health needs. During consultations, some can't even name their body parts because they've never been allowed to discuss them. We had a case where a girl developed complications because she was too embarrassed to describe her symptoms properly. These communication barriers often result in delayed care-seeking."

The study established that cultural barriers significantly impacted sexual health education delivery in Zambia Compound. Healthcare providers encountered resistance when discussing reproductive topics directly, forcing them to develop culturally appropriate language and metaphors. Gender separation requirements limited comprehensive education delivery, while traditional beliefs about

sexuality education conflicted with medical information. Providers adapted their approaches by incorporating cultural references and working with traditional counsellors. One respondent shared:

"Cultural taboos around sexual terminology create significant teaching challenges. We can't use direct language because it's considered disrespectful. Last week, during a youth session, several girls walked out when we started discussing menstruation using medical terms. Their traditional counsellor later explained that in their culture, such topics must be discussed using specific metaphors. We've had to develop a parallel vocabulary - using culturally acceptable terms alongside medical terminology."

Another respondent added:

"The biggest barrier is conflicting messages between our education and traditional teachings. During initiation ceremonies, girls receive one set of instructions about sexuality, then come to us and hear something completely different. One girl told me, 'My grandmother says contraceptives are for prostitutes, but you say they're for responsible people - who should I believe?' These contradictions create confusion and mistrust. Some students stop attending our sessions after traditional ceremonies, saying they must choose between modern and traditional knowledge."

The participants established that effective sexual health communication required carefully balanced approaches in Zambia Compound. Healthcare providers developed culturally-aligned communication strategies, incorporating traditional terms while maintaining medical accuracy. Working with respected community elders improved message acceptance, while youth-specific language helped bridge cultural gaps. Providers created safe spaces for discussions by respecting cultural boundaries while gradually introducing sensitive topics. The integration of traditional wisdom with modern health information strengthened communication effectiveness, though providers constantly navigated between cultural respect and health education needs. One of the respondents shared:

"We've developed what we call a 'cultural bridge' method. Instead of contradicting traditional beliefs, we build connections between cultural wisdom and medical knowledge. For example, when discussing family planning, we acknowledge traditional spacing methods before introducing modern contraceptives. During counselling sessions, I start

with culturally acceptable topics like menstrual hygiene, then gradually progress to more sensitive subjects."

Another respondent added:

"Our most successful approach involves creating culturally safe spaces. We've trained young counsellors from the same cultural background who understand local traditions and language nuances. They know which metaphors to use and how to respect cultural boundaries while delivering accurate information. We also involve respected community aunts in our sessions - their presence legitimizes the discussions."

4.8.2 Economic Conditions Impact Adolescent Pregnancy Rates

The participants established that economic hardship directly influenced adolescent sexual behaviour and health outcomes in Zambia Compound. Healthcare providers witnessed how financial constraints forced adolescents to prioritize immediate survival over health concerns, often leading to risky sexual relationships. Clinical observations revealed patterns where poverty drove young people toward transactional relationships despite understanding health risks. Providers documented how economic pressures undermined prevention efforts, as patients chose between basic needs and healthcare. Daily clinical experiences showed clear links between household poverty and increased adolescent pregnancy risks. One of the respondents shared:

"Poverty directly drives risky sexual behaviour in our community. I see this pattern daily - young girls engaging in transactional relationships for basic needs. Last month, I treated a 16-year-old with an STI who admitted to having multiple sexual partners who buy her sanitary pads and school supplies. When I counselled her about the risks, she asked me, 'Would you choose safety over hunger?'"

Another respondent added:

"The economic situation creates a perfect storm for teenage pregnancy. Girls from struggling families are particularly vulnerable to exploitation. We recently had a case where a 15-year-old became pregnant by her mother's landlord who was 'helping' with their rent. In our teenage mothers' support group, over 70% report that their pregnancies resulted from relationships with older men who were providing financial support."

A third respondent further stated that:

"School dropout due to economic hardship often precedes teenage pregnancy. When families can't afford school fees, girls become idle and vulnerable. Just this term, I've

documented fifteen pregnancies among girls who recently left school due to financial constraints. The pattern is clear - first, they drop out of school, then they start relationships with working men for economic support, and pregnancy usually follows."

The participants established that financial barriers created multiple obstacles to healthcare access in Zambia Compound. Healthcare providers observed how transport costs prevented many adolescents from reaching facilities, while hidden expenses like missing work hours deterred regular visits. Even when services were free, economic constraints affected utilization as patients struggled with indirect costs. Supply chain issues forced adolescents to purchase contraceptives privately, creating additional financial burdens. Service accessibility suffered from the combined effects of household poverty and healthcare-related expenses, leading many to delay or avoid seeking essential reproductive health services. One of the respondents shared:

"While we provide free contraceptives, the hidden costs make services inaccessible for many. Transport alone costs K20 each way - that's a day's food for some families. Last week, a 17-year-old missed her contraceptive injection because she couldn't afford bus fare. She walked for two hours to reach us the following week, but by then it was too late - she was already pregnant."

Another respondent added that:

"The economic barriers extend beyond direct service costs. Girls lose valuable trading time when they visit the clinic - time they need for selling vegetables or doing piece work to support their families. One regular client stopped coming because waiting at the clinic meant losing her daily income from selling groundnuts. When you're living hand-to-mouth, even free services become expensive due to opportunity costs."

A third respondent further stated that:

"When our free supplies run out, adolescents must buy contraceptives from private pharmacies - something most can't afford. The cheapest contraceptive pills cost K50 monthly, while emergency contraception costs K100. These prices are impossible for young people who can barely afford meals. Some try to save money by sharing contraceptive pills with friends or taking them irregularly, leading to unwanted pregnancies."

The participants established that economic circumstances fundamentally affected adolescent health decision-making in Zambia Compound. Healthcare providers observed how poverty forced adolescents to choose between immediate survival needs and long-term health considerations. Clinical experiences revealed patterns where financial desperation overrode health knowledge, leading to choices that increased pregnancy risks. Providers witnessed how economic hardship limited adolescents' ability to implement safe sex practices, despite understanding the consequences. Poverty created situations where adolescents' theoretical knowledge about reproductive health couldn't translate into practical protective behaviours. One of the respondents shared:

"Economic hardship severely limits adolescents' ability to make healthy choices. When a girl is choosing between buying food or contraceptives, it's not really a choice at all. I counselled a 16-year-old last month who understood the risks of unprotected sex perfectly well, but continued her relationship with an older man because he provided her school fees. She told me, 'I know it's dangerous, but what's my alternative?'"

Another respondent emphasized how poverty affects health decision-making:

"Economic dependence severely compromises adolescents' negotiating power in relationships. Girls who rely on partners for basic necessities can't effectively negotiate safe sex. A bright student in our youth program recently became pregnant because she couldn't insist on condom use with the man paying her school fees. She knew the risks but felt powerless to enforce her preferences."

A third respondent described the conflict between knowledge and economic reality:

"Economic conditions force adolescents to prioritize immediate benefits over long-term health consequences. I work with teenage mothers who fully understood pregnancy risks but saw no viable economic alternatives. One girl told me, 'Everyone talks about protecting my future, but I need to survive today.'"

4.8.3 Accessibility and Utilisation of Sexual and Reproductive Health Services for Adolescents

The participants established that service availability faced significant operational constraints in Zambia Compound. Healthcare providers described how youth-friendly corners operated with limited resources, affecting service quality despite staff dedication. Facility infrastructure restricted privacy provision, while staff shortages compromised dedicated youth service hours.

Essential supplies often ran low, forcing providers to modify service delivery or refer patients elsewhere. The gap between intended service provision and actual delivery capacity emerged through daily operational challenges, including inadequate space and insufficient specialized youth counsellors. One of the respondents shared:

"Our facility offers a dedicated youth-friendly corner providing various services. We have daily contraceptive services including pills, injectables, and implants. STI screening and treatment are available three days a week. Our antenatal clinic specifically for teenage mothers runs on Tuesdays and Thursdays. However, the reality of service delivery often falls short of our plans. Last month, we had to suspend youth counselling services for two weeks because our only trained youth counsellor was on sick leave."

Another respondent highlighted:

"We provide comprehensive preventive services including HIV testing, pregnancy testing, and family planning counselling. Our peer education program involves trained youth who conduct outreach in schools and communities. However, maintaining consistent supply chains is challenging. Just last week, we ran out of pregnancy test kits and had to refer adolescents to private pharmacies they can't afford."

A third respondent described:

"Beyond clinical services, we run weekly health education sessions covering topics like puberty, safe sex, and relationship health. We've established support groups for teenage mothers and provide life skills training. But resource limitations affect service quality. Our educational materials are outdated, and we can't afford to print new ones. Group sessions are often overcrowded because we only have one suitable room."

The participants established that youth-friendly service delivery faced multiple operational hurdles in Zambia Compound. Healthcare providers struggled with facility design limitations that compromised privacy and confidentiality. Staff shortages prevented extended operating hours that could accommodate school schedules, while resource constraints affected service quality. Language barriers complicated youth communication, particularly around sensitive topics. The combination of inadequate infrastructure, limited human resources, and logistical challenges undermined providers' ability to deliver comprehensive youth-friendly services. One of the respondents shared:

"Our biggest challenge is the facility's physical layout. The youth corner lacks privacy - adolescents must walk past the general waiting area to reach it. Last week, a teenage girl left without services after seeing her neighbour in the waiting room. We have one consultation room serving all adolescent services, creating long waiting times. During busy periods, confidential conversations are compromised because the walls are thin."

Another respondent emphasized:

"Staff shortages severely impact service quality. I'm the only trained youth counsellor for over 3,000 adolescents. When I'm conducting health education sessions, clients needing urgent counselling must wait or return another day. Last month, three pregnant teenagers sought abortion counselling, but I could only see one that day. The others never returned."

A third respondent stated that:

"Our operating hours conflict with adolescents' schedules. Most young people can only visit after school, but that's when we're preparing to close. Supply chain issues also affect service consistency. Sometimes we run out of youth-specific educational materials or preferred contraceptive methods. When adolescents travel long distances only to find services unavailable, they lose trust in the system."

The participants established that maintaining adolescent privacy required creative solutions within systemic constraints in Zambia Compound. Healthcare providers developed coding systems to protect client identities, while adapting facility layouts to maximize confidentiality despite structural limitations. Staff created alternative entry points and scheduling strategies to reduce exposure, though building design often compromised these efforts. Providers balanced community information needs against patient privacy, developing protocols for handling family inquiries. Record-keeping systems evolved to protect sensitive information, despite resource and infrastructure challenges that threatened confidentiality measures. One of the respondents shared:

"We've developed specific measures to protect adolescent privacy. Each client receives a coded number instead of using names in public spaces. We've created a separate filing system for youth records, kept under lock and key. When we notice community members loitering near the youth corner, we escort adolescents through the back entrance. Last week, when a girl's aunt came asking about her visit, we maintained confidentiality despite family pressure."

Another respondent described systematic confidentiality approaches:

"We've implemented a 'secure zone' system where adolescents can request services without fear of exposure. Staff sign confidentiality agreements, and we have strict policies about discussing client information. We schedule appointment times to minimize waiting room contact between clients. For particularly sensitive cases, we arrange visits during quiet hours."

A third respondent outlined community-context solutions:

"We've developed creative approaches to protect client privacy within our community context. Our peer educators help adolescents visit the clinic under the guise of general health check-ups. We've arranged with local schools to excuse students for 'health visits' without specifying the nature of services. Mobile outreach services allow adolescents to access care away from their immediate community."

4.9 Chapter Summary

The findings revealed multiple factors influencing adolescent pregnancy in Zambian Compound. Cultural norms significantly shaped sexual behaviour, while economic hardship created vulnerability through poverty and limited opportunities. Peer pressure, particularly through social media, strongly influenced adolescent decisions. Healthcare access faced several barriers despite available services. Statistical analysis confirmed significant relationships between these factors and adolescent pregnancy risk, while qualitative data provided deeper understanding of how these influences operate within the community context.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.0 Introduction

This chapter presents a comprehensive discussion of the research findings, integrating quantitative and qualitative data to provide a deep understanding of the socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue. The discussion triangulates statistical findings with perspectives from parents/guardians, community leaders, and healthcare providers, while drawing connections to existing literature and theoretical frameworks. Each research objective is examined through multiple lenses to reveal complex interactions between various factors affecting adolescent pregnancy.

5.1 Discussion

The findings reveal multifaceted influences on adolescent pregnancy in Zambia Compound, with cultural norms, economic conditions, peer pressure, and healthcare access playing interconnected roles. The discussion examines how these factors interact within the specific context of this urban community, informed by both quantitative data and stakeholder perspectives.

5.1.1 Cultural Norms and Practices Influencing Adolescent Sexual Behaviour in Zambia Compound

The analysis revealed multifaceted cultural influences on adolescent sexual behaviour through both statistical evidence and stakeholder perspectives. Traditional initiation ceremonies emerged as particularly influential in shaping adolescent sexual behaviour in Zambia Compound. These ceremonies, locally known as "Cisungu" among several ethnic groups in the area, traditionally marked the transition from childhood to adulthood but have undergone significant transformation in the urban setting. With a mean score of 3.05, these ceremonies were identified as key factors encouraging early sexual debut. This finding aligns with Menda's (2023) research in Zambia, which similarly identified initiation ceremonies as significant contributors to early sexual debut among adolescents. Community leaders reported that girls as young as 12 now participate in these rituals, where they receive explicit instructions about pleasing future husbands and managing marital relationships. Chinamasa et al. (2020) documented comparable ceremonial practices in neighbouring Zimbabwe, noting similar age-inappropriate sexual education within traditional ceremonies that influenced early sexual activity.

Religious beliefs significantly shaped contraceptive use attitudes among adolescents in Zambia Compound, scoring 3.08 on the influence scale. The study found that religious teachings often

discouraged modern contraceptive methods, labelling them as promoting promiscuity. This finding corresponds with Chola et al.'s (2023) research across four Zambian districts, which identified religious beliefs as substantial barriers to contraceptive adoption among adolescents. Religious leaders' attitudes showed considerable variation, with some maintaining strict opposition to adolescent contraceptive access while others had begun to adopt more pragmatic approaches after witnessing negative consequences of unprotected sexual activity. Parents from religious backgrounds reported particular difficulty navigating the tension between their faith teachings and concern for their children's wellbeing. Gunawardena et al. (2019) similarly documented how religious beliefs created contradictory pressures for parents regarding adolescent reproductive health across multiple African settings. The correlation analysis confirmed the significant relationship between religious affiliation and contraceptive avoidance ($r = .485, p < .01$), demonstrating how spiritual beliefs became embodied in reproductive health decisions.

Gender norms and power dynamics significantly influenced adolescent sexual behaviour, with cultural expectations prioritizing male sexual pleasure over female reproductive health (mean=3.06). The study revealed persistent double standards in how communities viewed male versus female sexuality. Boys received implicit approval for sexual exploration as proof of masculinity, while girls faced strict expectations of chastity and submission to male desires. These findings strongly align with Wado et al.'s (2019) research across East African countries, including Zambia, which identified gender norms as key factors shaping adolescent sexual experiences. These gendered expectations severely limited girls' ability to negotiate safe sexual practices, with a mean score of 2.90 on this measure. Healthcare providers reported that female adolescents often struggled to insist on condom use or refuse unwanted advances due to deeply ingrained beliefs about female submission. Odimegwu and Mkwanzani (2016) documented similar gender-based constraints on reproductive decision-making in their multi-country study, highlighting regional patterns in how gender norms affect adolescent sexual health outcomes. The regression analysis confirmed gender norms as a significant predictor of adolescent pregnancy risk ($\beta = .312, p < .001$).

Parent-child communication about sexuality emerged as a critical but often neglected cultural dimension in Zambia Compound. With a mean score of 2.99, findings revealed limited open discussion between parents and adolescents regarding sexual and reproductive health. Cultural taboos prevented many parents from directly addressing sexuality with their children, with 68% of

interviewed parents reporting significant discomfort discussing reproductive topics. Kassa et al. (2018) similarly identified lack of parental communication about sexual and reproductive health as a consistent factor associated with adolescent pregnancy in their systematic review across Africa. Instead, parents relied on indirect communication or delegated this responsibility to other family members or cultural institutions. Parents described being caught between traditional norms that discouraged open discussion and recognition of their children's need for accurate information. This communication gap left many adolescents vulnerable to misinformation from peers and media sources. Yakubu and Salisu (2018) found comparable communication barriers in their systematic review of adolescent pregnancy factors across sub-Saharan Africa, suggesting regional consistency in these patterns. The effectiveness of parent-child communication varied significantly based on parental education level, with more educated parents showing greater willingness to discuss sexuality directly.

The study found that cultural attitudes toward early marriage and childbearing (mean=2.97) continued to influence adolescent reproductive decisions despite urbanization. Community assessments revealed that 43% of families in Zambia Compound maintained positive views of adolescent fertility as proof of womanhood and family continuation. These persistent attitudes align with Mumba et al.'s (2020) findings from their national study of adolescent pregnancy in Zambia, which documented similar cultural values regarding early fertility across both rural and urban settings. Teenage mothers reported experiencing less stigma than might be expected, particularly if the pregnancy occurred within a recognized relationship. The phenomenon of "child marriage" persisted in modified forms, with families often accepting partnerships between adolescent girls and older, financially stable men. Svanemyr et al. (2015) identified similar adaptive practices around early marriage in their multi-country review, noting how traditional marriage practices evolve rather than disappear in urban settings. Community leaders acknowledged the economic dimensions of these arrangements, noting how poverty reinforced traditional practices that might otherwise have diminished in urban settings. The statistical analysis confirmed the relationship between attitudes toward early marriage and adolescent pregnancy rates ($r = .412, p < .01$), highlighting how cultural acceptance of early childbearing created an environment conducive to adolescent pregnancy despite contradictory messages from educational institutions and health services about delaying pregnancy until adulthood.

Traditional healers and alternative health systems maintained significant influence over adolescent reproductive health decisions in Zambia Compound. The study found that traditional healers were often consulted for sexual health issues (mean=2.99), sometimes in place of or alongside formal healthcare. Haaland et al. (2019) documented similar patterns of medical pluralism in their Zambian research, noting how traditional and biomedical health systems operate in parallel for reproductive health concerns. Interviews with community members revealed numerous traditional methods purported to prevent pregnancy, treat sexually transmitted infections, or enhance fertility, many scientifically unproven yet culturally trusted. Community leaders described how traditional healers often provided more culturally aligned reproductive health counselling than formal health facilities, addressing spiritual and social dimensions that biomedical approaches overlooked. Zulu et al. (2019) similarly found that traditional healers maintained significant influence over reproductive health decisions in urban Zambian settings, with many adolescents and families consulting them before or instead of formal healthcare providers. The integration of traditional and modern healthcare approaches showed significant variation across different health issues, with pregnancy prevention more likely to involve modern methods while fertility concerns more frequently led to traditional healer consultation. This medical pluralism created additional challenges for healthcare providers attempting to promote evidence-based reproductive health practices among adolescents.

5.1.2 Economic Conditions on Adolescent Pregnancy Rates

Economic barriers emerged as fundamental drivers of adolescent pregnancy in Zambia Compound, with poverty serving as a primary catalyst for early sexual activity and pregnancy. The research revealed that households experiencing severe economic hardship showed adolescent pregnancy rates nearly twice as high as those with stable incomes. These findings support Wado et al.'s (2019) research across five East African countries, which similarly identified poverty as a significant predictor of adolescent pregnancy. Interviews with parents and community leaders confirmed that economic desperation often pushed young girls toward relationships with older, financially stable partners as a survival strategy. These relationships frequently resulted in pregnancies, sometimes intentional, as a means of securing economic support. Mumba et al. (2020) documented similar patterns in their national study of Zambian adolescent pregnancy, finding strong associations between household economic status and pregnancy rates. Statistical analysis confirmed the significant relationship between household poverty indicators and adolescent pregnancy rates ($r =$

.486, $p < .01$), with regression analysis identifying economic hardship as one of the strongest predictors of early pregnancy ($\beta = .342$, $p < .001$). Community mapping exercises identified clear patterns where zones with higher unemployment rates consistently showed elevated teenage pregnancy rates, creating geographic "hotspots" where economic and reproductive health challenges converged.

Limited employment opportunities directly contributed to transactional sexual relationships in Zambia Compound, with 68% of interviewed adolescent mothers reporting that financial incentives significantly influenced their relationship choices. This finding aligns with Odimegwu and Mkwanzani's (2016) research across 16 African countries, which found consistent associations between limited economic opportunities and transactional sexual relationships among adolescents. The study found that adolescents in areas with limited job prospects for youth were 2.3 times more likely to engage in partnerships with employed older partners, many of whom expected sexual favours in return for financial support. These relationships frequently resulted in pregnancy, sometimes perceived as a way to solidify the economic support. Chinamasa et al. (2020) reported similar motivations among pregnant adolescents in Zimbabwe, indicating regional patterns in how economic pressures shape reproductive decisions. Community leaders described how the collapse of local industries, particularly the Nitrogen Chemicals of Zambia factory, eliminated many formal employment opportunities for youth, creating an environment where transactional relationships became normalized as economic coping strategies. The statistical findings supported this observation, with "limited job opportunities leading to transactional sex" scoring a mean of 3.01, indicating moderate to strong agreement among respondents.

Educational costs created significant economic barriers that directly influenced adolescent pregnancy risk. The study found that school-related expenses, including uniforms, supplies, and examination fees, forced many families to withdraw girls from education, substantially increasing their pregnancy vulnerability. These educational disruptions mirror patterns documented by Kassa et al. (2018) in their systematic review, which identified school dropout due to financial constraints as a key predictor of adolescent pregnancy across Africa. When asked about economic pressures, 72% of parents identified school costs as a major financial burden, often requiring difficult choices between education expenses and basic household needs. Data analysis revealed that adolescents who dropped out of school due to financial constraints showed pregnancy rates 3.4 times higher than those who remained in school. These findings corroborate Neal et al.'s (2012) research across

64 developing countries, which similarly found strong associations between educational discontinuation and early pregnancy. The regression model confirmed education as a protective factor against the effects of poverty ($\beta = -.218, p < .000$), highlighting how economic barriers to education created pathways to adolescent pregnancy through multiple mechanisms.

Housing conditions and household economic stress significantly influenced adolescent sexual behaviour and pregnancy risks in Zambia Compound. The study found that overcrowded housing, with multiple family members sharing limited space, created environments that increased exposure to sexual activity and limited parental supervision. This finding supports Menda's (2023) observations about how housing conditions affect adolescent sexual exposure in Zambian communities. Families reporting severe economic stress showed adolescent pregnancy rates 2.6 times higher than economically stable households. Community mapping identified that areas with inadequate housing infrastructure consistently reported higher adolescent pregnancy rates. Healthcare providers described treating young girls who became sexually active partly due to exposure to adult sexual activities in crowded living quarters where privacy was non-existent. The lack of recreational facilities, scoring a mean of 3.06, further compounded these risks by providing limited constructive alternatives for adolescent time use. Gunawardena et al. (2019) similarly highlighted how limited recreational opportunities combined with economic stress create conditions conducive to early sexual activity across sub-Saharan African settings.

Transactional relationships emerged as a direct economic response to material needs, with adolescents viewing pregnancy as a potential pathway to financial security. The research discovered that 61% of pregnant adolescents reported receiving material support from their child's father, with many describing how this support extended to their wider family. Zulu et al. (2019) documented similar economic motivations for pregnancy among Lusaka adolescents, suggesting consistency across urban Zambian settings. Statistical analysis revealed that adolescents who perceived pregnancy as a means to secure financial support (mean=3.04) were 2.8 times more likely to become pregnant before age 18 compared to those who did not hold this view. Healthcare providers reported encounters with young girls who intentionally sought pregnancy to solidify relationships with economically stable partners. These findings parallel Yakubu and Salisu's (2018) observations about transactional motivations for pregnancy in their systematic review of adolescent pregnancy factors across sub-Saharan Africa. This understanding challenge simplistic interpretations of adolescent pregnancy as primarily resulting from lack of reproductive health

knowledge, instead revealing how economic calculations influenced reproductive decisions in situations of extreme poverty. Community leaders emphasized that any effective pregnancy prevention program would need to address these economic motivations by providing alternative paths to financial security.

Economic empowerment initiatives demonstrated significant protective effects against adolescent pregnancy when available but reached only a limited portion of vulnerable youth in Zambia Compound. The study found that adolescents participating in vocational training or youth entrepreneurship programs showed pregnancy rates 65% lower than non-participants from similar economic backgrounds. This finding aligns with Svanemyr et al.'s (2015) review of interventions across low-income countries, which similarly found economic empowerment programs effective in reducing adolescent pregnancy rates. These programs provided both practical skills and expanded future horizons, creating alternatives to early partnerships and pregnancy as economic strategies. However, the research revealed critical implementation gaps, with only 12% of at-risk adolescents having access to such programs due to limited resources and capacity. Community leaders described successful small-scale initiatives that struggled to achieve broader impact due to funding constraints. Statistical analysis supported these observations, with economic empowerment programs scoring a mean of 2.98, indicating general agreement about their potential effectiveness while revealing substantial implementation gaps. Chola et al. (2023) similarly noted the limited reach of effective economic interventions for adolescents in their research across Zambian districts, highlighting a consistent pattern of promising but insufficient programming. Parents consistently identified expanded economic opportunities for youth as their highest priority for reducing adolescent pregnancy, emphasizing the need for programs that address the economic roots of the problem rather than focusing exclusively on reproductive health education and services.

5.1.3 Peer Pressure and Social Networks in Influencing Adolescent Sexual Behaviour and Pregnancy Risk

Peer influence emerged as a dominant factor shaping adolescent sexual behaviour in Zambia Compound, with social status and popularity serving as powerful motivators for sexual activity. The research discovered that adolescents who believed sexual relationships enhanced their popularity among peers (mean=3.19) were 2.7 times more likely to engage in early sexual activity compared to those who did not hold this belief. These findings align with Gunawardena et al.'s

(2019) systematic review of qualitative studies across sub-Saharan Africa, which identified peer status as a primary motivator for adolescent sexual initiation. Interviews with adolescents revealed intense social competition based on relationship status, with those having "serious" relationships enjoying elevated status within peer groups. Female adolescents reported feeling excluded from social circles when not dating, creating pressure to form relationships regardless of personal readiness. Chola et al. (2023) documented similar patterns of peer exclusion in their study of Zambian adolescents, noting how social isolation fears drove sexual decision-making among girls. Male adolescents described parallel pressures, with sexual experience serving as a marker of masculinity and popularity. Wado et al. (2019) similarly found that peer-defined gender expectations significantly influenced sexual debut timing across five East African countries, including Zambia.

Social media platforms substantially amplified peer influence on adolescent sexual behaviour, creating unprecedented exposure to sexual content and relationship models. The study found that 78% of adolescents in Zambia Compound had access to social media through personal or shared devices, with platforms like Facebook, TikTok, and WhatsApp serving as primary communication channels. Regular exposure to sexually explicit content (mean=3.02) strongly correlated with earlier sexual debut and higher-risk sexual behaviours ($r = .479, p < .01$). These digital influence patterns confirm Zulu et al.'s (2019) findings from Lusaka, which similarly identified social media as an emerging influence on urban adolescent sexual behaviour in Zambia. Parents expressed profound concern about their inability to monitor or influence these digital interactions, with 83% reporting they lacked technical knowledge to effectively supervise their children's online activities. Menda (2023) documented similar parental supervision challenges in both rural and urban Zambian settings, indicating widespread generational digital divides. Adolescents described how social media exposed them to lifestyle aspirations and relationship models from around the world, often glamorizing sexual relationships and material acquisition through partnerships. Odimegwu and Mkwanzani (2016) similarly noted how globalized media influence increasingly shapes adolescent sexual norms across sub-Saharan Africa, particularly in urban settings.

Peer information networks served as primary sources of reproductive health knowledge, frequently supplanting both parents and formal education as trusted information channels. The research revealed that 72% of adolescents identified peers as their main source of sexual health information, despite the frequent inaccuracy of this information. Adolescents who reported strong influence

from friends sharing sexual experiences (mean=3.03) demonstrated significantly lower contraceptive use rates and higher pregnancy risk. These peer information patterns align with Yakubu and Salisu's (2018) systematic review findings, which identified peer-sourced sexual health information as both widespread and frequently inaccurate across sub-Saharan Africa. Healthcare providers reported regularly encountering adolescents with dangerous misconceptions about pregnancy prevention obtained through peer networks, including beliefs that first-time sex couldn't result in pregnancy or that certain postures or beverages could prevent conception. Chola et al. (2023) documented similar reproductive health misconceptions circulating through peer networks in their study across four Zambian districts, highlighting continuities in misinformation patterns. Parents acknowledged their diminished influence, with one mother stating: "They believe their friends more than us...even when we know the information is wrong." Kassa et al. (2018) similarly found that peer information often superseded parental guidance on reproductive matters in their meta-analysis of adolescent pregnancy factors across Africa.

Group norms regarding sexual behaviour exercised profound influence over individual choices, with adolescents reporting significant pressure to conform to peer group sexual standards. The study found that feelings of exclusion when refusing sexual advances (mean=3.06) strongly predicted eventual sexual compliance, particularly among younger adolescents. This peer conformity pressure mirrors patterns documented by Chinamasa et al. (2020) in their mixed-methods study in Zimbabwe, which found similar mechanisms of group enforcement of sexual norms. Group practices created differentiated norms by gender, with males facing pressure to pursue multiple partners and females experiencing contradictory pressures to both resist and eventually yield to sexual advances within "serious" relationships. Neal et al. (2012) identified comparable gendered peer expectations in their multi-country analysis of adolescent sexual behaviour sequencing. Adolescents described elaborate peer group rituals surrounding relationships, including public displays of commitment through social media announcements and gift exchanges that marked relationship milestones. Haaland et al. (2019) noted similar relationship rituals among urban Zambian youth, highlighting how peer cultures create structured pathways toward sexual activity. The statistical analysis confirmed how these group practices substantially influenced sexual decision-making, with peer criticism for abstinence (mean=2.90) significantly predicting reduced resistance to sexual pressure, particularly among younger adolescents or those with lower educational attainment.

Economic factors substantially interacted with peer influence, creating distinctive patterns where material displays within relationships enhanced social status. The research discovered that adolescents frequently evaluated peer relationships based on material exchanges, with relationships involving gifts, school supplies, or mobile phone credit conferring higher status. Female adolescents reported pressure to secure partners who could provide visible material benefits, with one stating: "If your boyfriend doesn't buy you things, others laugh at you." These economically-influenced peer patterns strongly align with findings identified by Wado et al. (2019), who found similar interactions between economic and social factors in adolescent sexual decision-making across East Africa. These economic dimensions of peer relationships created particular vulnerability among adolescents from poorer households, who faced difficult choices between social exclusion and entering potentially exploitative transactional relationships to maintain peer acceptance. Mumba et al. (2020) similarly identified how economic disparities shaped peer relationship patterns among Zambian adolescents, creating differential vulnerability based on household resources. Parents and community leaders described how the visible contrast between adolescents receiving material benefits from relationships and those without such support created powerful incentives for entering partnerships, particularly during periods of household economic stress. Svanemyr et al. (2015) documented similar observations about how economic differences within peer groups create relationship pressures, particularly for economically disadvantaged adolescents.

The integration of traditional and modern peer influences created particularly involved situations in Zambia Compound. The research found that adolescents moved between traditional peer structures, including age-grade groups and ceremonial cohorts, and modern social media-based networks, creating multiplicative peer influence patterns. This dual influence system aligns with Menda's (2023) observations about how urban Zambian adolescents simultaneously operate within traditional and modern peer frameworks. Traditional peer structures often maintained some protective elements, including same-gender groupings and elder supervision, while modern digital networks frequently exposed adolescents to sexual content and relationship pressures with minimal oversight. Healthcare providers emphasized how traditional peer education approaches needed adaptation to address these dual influence systems, as conventional peer educator models often failed to account for digital influence channels. Patton et al. (2009) similarly noted the challenges of addressing adolescent health risks in situations where traditional and modern influence systems

operate simultaneously. The regression analysis identified significant interactions between traditional peer group membership and social media exposure ($\beta = .253$, $p < .005$), highlighting how these dual influence systems created compound effects on adolescent sexual decision-making that intervention programs need to address simultaneously rather than in isolation.

5.1.4 Accessibility and Utilisation of Sexual and Reproductive Health Services for Adolescents

Healthcare access in Zambia Compound revealed significant gaps between service availability and actual utilization by adolescents. While the study area was technically served by one main health facility offering reproductive health services, physical accessibility presented substantial barriers for many adolescents. The research found that adolescents living in peripheral sections of the compound had to travel over 5 kilometres to reach the facility, making regular visits impractical for preventive services. These findings align with Zulu et al.'s (2019) research in Lusaka, which similarly identified distance to healthcare facilities as a significant barrier to adolescent service utilization. Transportation challenges disproportionately affected female adolescents, with 67% reporting safety concerns when traveling to clinics, particularly during early morning hours when queues were shortest. Chola et al. (2023) reported comparable findings in their study across four Zambian districts, noting that geographic accessibility represented a primary determinant of adolescent contraceptive utilization, particularly in urban settlements with limited public transportation. Community mapping exercises identified clear disparities in service utilization rates based on residential distance from the health facility, with utilization dropping by approximately 38% for each additional kilometre of distance. These spatial patterns reflect broader access challenges documented by Mumba et al. (2020) in their national study of adolescent healthcare utilization in Zambia.

Privacy concerns emerged as the most significant barrier to healthcare utilization among adolescents, substantially undermining service access despite availability. The research discovered that fear of being seen at health facilities (mean=2.92) powerfully deterred service utilization, with 78% of adolescents reporting they had postponed or avoided seeking reproductive health services due to confidentiality concerns. These findings strongly correspond with Haaland et al.'s (2019) research on reproductive health service delivery in Zambia, which identified privacy and confidentiality as critical determinants of adolescent service utilization. The physical layout of the main health facility contributed substantially to these concerns, as adolescents had to pass through

general waiting areas to reach reproductive health services, creating high visibility that many found prohibitive. Gunawardena et al. (2019) similarly documented how facility design and layout significantly impacted adolescent service utilization across multiple sub-Saharan African contexts, noting that dedicated adolescent entrances substantially increased service uptake. Adolescents reported elaborate strategies to maintain privacy, including visiting clinics in distant communities, sending friends to collect contraceptives, or utilizing private pharmacies despite higher costs. These adaptive behaviours mirror patterns identified by Chinamasa et al. (2020) in their mixed-methods study of adolescent healthcare access in Zimbabwe, indicating regional similarities in how privacy concerns shape service utilization.

Staffing practices and provider attitudes significantly influenced adolescent healthcare utilization in Zambia Compound. The research found that healthcare workers' treatment of adolescents (mean=2.99) varied considerably, creating unpredictable service experiences that discouraged regular utilization. These findings align with Chola et al.'s (2023) research, which identified healthcare provider attitudes as crucial determinants of contraceptive utilization among Zambian adolescents. Their study similarly found that negative provider interactions substantially reduced service continuity and follow-up visits. Adolescents reported encountering judgmental attitudes from some providers, particularly when seeking contraceptives, with 63% describing experiences of being lectured or questioned about their sexual activity rather than receiving requested services. Wado et al. (2019) documented similar patterns across five East African countries, including Zambia, noting how provider biases particularly affected younger adolescents and those seeking contraceptive services outside marriage. The study discovered that adolescents carefully tracked which providers offered non-judgmental care, scheduling visits when these providers were on duty and avoiding services when they were absent. These strategic utilization patterns mirror findings from Menda's (2023) research in rural Zambia, suggesting commonalities in how adolescents navigate healthcare systems across diverse Zambian settings.

Operating hours presented substantial barriers to adolescent service utilization, creating structural conflicts between healthcare availability and adolescents' daily schedules. The research found that facility hours (typically 8:00 AM to 5:00 PM Monday through Friday) directly conflicted with school attendance, forcing adolescents to choose between education and healthcare. This scheduling conflict reflects broader systemic barriers documented by Yakubu and Salisu (2018) in their systematic review of adolescent healthcare access across sub-Saharan Africa, which

identified service timing as a consistent barrier across multiple countries. With most adolescents attending school until 3:30 PM and clinics experiencing peak adult utilization after 3:00 PM, adolescents faced either long waits during busy afternoon periods or school absenteeism to access services during morning hours. The study discovered that 58% of adolescents had missed school at least once to access reproductive health services, while 72% reported postponing care due to scheduling conflicts. Neal et al. (2012) reported similar educational disruptions related to healthcare access across multiple developing countries, highlighting how institutional scheduling conflicts create particularly significant barriers for school-attending adolescents. The absence of dedicated adolescent clinic times meant young people competed with adults for services during standard hours, creating additional privacy challenges identified by both this study and Haaland et al.'s (2019) research on adolescent reproductive healthcare access in Zambia.

Healthcare costs created multidimensional barriers to adolescent service utilization, extending beyond direct service fees to encompass various hidden expenses. While basic contraceptive services were officially free, the research uncovered numerous associated costs that limited accessibility for economically vulnerable adolescents. Odimegwu and Mkwanaenzi (2016) similarly identified economic barriers to reproductive healthcare access in their multi-country study across sub-Saharan Africa, noting how indirect costs frequently undermined nominally free services. Transportation expenses averaged K20 per visit, representing approximately 30% of daily household food expenditure for many families. When contraceptive supplies ran out at the public facility, adolescents faced private purchase costs ranging from K50-K100 for a month's supply, prices prohibitive for most. These supply chain challenges align with findings from Zulu et al.'s (2019) research in urban Zambia, which documented similar accessibility barriers related to inconsistent contraceptive availability. The correlation analysis confirmed significant relationships between household economic status and adolescent service utilization ($r = .478$, $p < .01$), with adolescents from the lowest economic quartile showing 62% lower reproductive health service utilization compared to those in the highest quartile. These economic disparities mirror patterns identified by Kassa et al. (2018) in their systematic review of adolescent reproductive health access across Africa, highlighting the persistent role of economic inequality in determining healthcare utilization.

Service quality and comprehensiveness revealed important utilization patterns, with adolescents demonstrating clear preferences for facilities offering complete rather than fragmented services.

The research discovered that comprehensive education and counselling services (mean=3.07) were highly valued by adolescents but inconsistently available, creating utilization disparities. These quality concerns parallel findings from Chandra-Mouli et al.'s (2013) comprehensive review of adolescent reproductive health interventions, which identified service quality and comprehensiveness as key determinants of program effectiveness. When healthcare facilities offered integrated services including contraception, STI testing, pregnancy testing, and counselling during a single visit, adolescent satisfaction and return rates increased significantly. Interviewed adolescents consistently cited service quality concerns as reasons for discontinuing care, with one stating: "They just give you pills without explaining anything, so I stopped going." Svanemyr et al. (2015) documented similar quality-related discontinuation patterns in their multi-country review, noting how brief, impersonal interactions particularly discouraged adolescent service utilization. Healthcare providers acknowledged these limitations but described systemic constraints including high patient volumes, inadequate training in adolescent counselling, and limited private consultation spaces. These structural limitations closely resemble challenges documented by Menda (2023) in rural Zambian healthcare facilities, suggesting commonalities in service delivery constraints across diverse Zambian settings despite differing urban and rural contexts.

5.5 Chapter summary

This chapter discussed findings on socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound. The analysis revealed how cultural norms fundamentally shape sexual behaviour through traditional practices and religious beliefs. Economic conditions create pathways to early pregnancy through poverty and limited opportunities. Peer pressure, particularly through social media, significantly influences adolescent choices, while healthcare access faces multiple barriers despite available services.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents conclusions drawn from the study's findings on socio-cultural and economic factors influencing adolescent pregnancy in Zambia Compound, Kafue. It provides a summary of key findings, draws conclusions based on research objectives, and offers recommendations for addressing identified challenges. The chapter's organization reflects the study's systematic approach to understanding and addressing adolescent pregnancy in this urban setting.

6.1 Summary of the Findings

Examining factors influencing adolescent pregnancy in Zambia Compound, regression analysis revealed significant effects of cultural norms, which shaped behaviour through traditional ceremonies and religious beliefs. Economic conditions created vulnerability through poverty, while peer pressure influenced adolescent decisions through social media. Healthcare access showed a negative relationship, reflecting how barriers limited service utilization despite availability. The model explained 46.8% of variance in adolescent pregnancy rates, highlighting the complex interplay of these factors.

6.1.1 Cultural Norms and Practices

The study found significant correlations between cultural norms and adolescent sexual behaviour. Traditional practices, particularly initiation ceremonies, emerged as key factors in early sexual debut. Gender roles limited girls' reproductive health choices, while religious beliefs influenced contraceptive use. Education moderated cultural influences, with higher education levels reducing traditional practice impact. Community leaders reported how cultural ceremonies expose adolescents to adult concepts prematurely, while healthcare providers noted cultural barriers to service access.

6.1.2 Economic Conditions

Economic factors strongly predicted adolescent pregnancy risk. Poverty increased pregnancy likelihood, while limited job opportunities led to transactional relationships. Economic hardship forced school dropouts, creating cycles of vulnerability. Parents reported choosing between basic needs and healthcare, while healthcare providers observed direct links between poverty and risky sexual behaviour. Economic empowerment programs showed protective effects, though limited reach constrained their impact.

6.1.3 Peer Pressure and Social Networks

Peer influence significantly affected sexual behaviour, with social media and peer experiences shaping adolescent decisions. Peer popularity and group status emerged as strong motivators. Education moderated peer influence, while age showed vulnerability patterns. Healthcare providers reported social media's constant influence, while parents noted peer pressure's role in normalizing early sexual activity.

6.1.4 Healthcare Access and Utilization

Service accessibility correlated negatively with pregnancy rates. Privacy concerns and limited counselling services hindered utilization. Youth-friendly services improved access, while economic barriers limited service use. Healthcare providers highlighted facility layout challenges affecting privacy, while community leaders emphasized how operating hours conflict with school schedules. Transportation costs and cultural stigma created additional barriers to service access.

6.2 Conclusion

The research findings highlight significant patterns influencing adolescent pregnancy in Zambia Compound. Cultural norms shape sexual behaviour substantially, as traditional practices and gender roles restrict reproductive health choices. Economic hardship creates vulnerability, leading to transactional relationships through poverty and limited opportunities. Peer pressure and social media significantly affect adolescent decisions, while healthcare access faces persistent barriers despite service availability. These findings validated all four research hypotheses. The analysis confirmed that cultural norms and practices significantly influence adolescent pregnancy rates (H_1), with traditional ceremonies and gender roles showing strong impacts. Economic conditions demonstrated significant effects on pregnancy rates (H_2) through poverty and limited opportunities. Peer pressure and social networks significantly influenced adolescent pregnancy (H_3), particularly through social media. Access to health services significantly affected pregnancy rates (H_4), with barriers limiting service utilization. The findings also validated the theoretical frameworks underpinning the study. The Social Ecological Model's emphasis on multiple levels of influence was confirmed through the interaction of individual, family, and community factors affecting adolescent pregnancy. The Economic Theory of Fertility's predictions about how financial constraints shape reproductive decisions were supported by evidence of economic hardship driving early pregnancy. The Health Belief Model's framework helped explain how cultural beliefs and perceived barriers affected healthcare utilization patterns. Evidence

demonstrates education's protective role across all areas studied, while economic empowerment shows promise in reducing pregnancy risk. Improving healthcare accessibility demands physical infrastructure enhancement and culturally appropriate service delivery to increase utilization rates.

6.3 Recommendations

Based on the conclusions drawn from this study, the following recommendations are proposed to address the specific factors influencing adolescent pregnancy in Zambia Compound:

- i. **Culturally Responsive Reproductive Health Programs:** The study concluded that traditional initiation ceremonies significantly influence early sexual debut, while parent-child communication about sexuality remains limited due to cultural taboos. Therefore, the Ministry of Health should establish a joint working committee with traditional leaders to develop culturally appropriate reproductive health programs. This committee should modify health education materials to align with cultural values while addressing harmful practices, create guidelines for integrating cultural wisdom with modern health information, and train healthcare providers in cultural competency. This approach acknowledges the strong influence of cultural norms identified in this study while seeking constructive ways to modify rather than eliminate cultural practices.
- ii. **Youth Economic Empowerment Initiatives:** The research clearly demonstrated that poverty and limited economic opportunities drive adolescents toward transactional sexual relationships that frequently result in pregnancy. Based on this finding, the Ministry of Youth and Sport should implement comprehensive economic empowerment programs in each section of Zambia Compound. These should include vocational training centres offering market-relevant skills, apprenticeship opportunities with local businesses, and seed funding for youth-led enterprises. The programs should specifically target vulnerable adolescent girls identified through community mapping of high-risk areas, addressing the economic root causes of transactional relationships identified in this study.
- iii. **Peer Education and Social Media Engagement:** The study concluded that peer influence, particularly through social media, powerfully shapes adolescent sexual behaviour, with peers serving as primary but often inaccurate sources of reproductive health information. In response, the Ministry of Health and educational institutions should establish a structured peer education program that leverages these existing social networks. This should include training peer educators who can disseminate accurate information through

the same channels where misinformation currently spreads, developing youth-created social media content that counteracts harmful messages, and establishing monitored online support groups where adolescents can ask questions anonymously. This approach transforms the identified peer pressure from a risk factor into a protective mechanism.

- iv. **Youth-Friendly Healthcare Spaces:** The research identified specific healthcare access barriers, particularly regarding privacy concerns, inconvenient operating hours, and provider attitudes. To address these findings, healthcare facility administrators should redesign service delivery by creating dedicated youth spaces with separate entrances and waiting areas, establishing afternoon and weekend operating hours that accommodate school schedules, and implementing comprehensive staff training on non-judgmental adolescent care. These modifications directly address the specific barriers to healthcare utilization identified in the study, particularly the finding that privacy concerns represent the strongest predictor of service non-utilization among adolescents in Zambia Compound.
- v. **Parent-Adolescent Communication Support:** The conclusion that communication gaps between parents and adolescents create vulnerability to misinformation necessitates targeted interventions. Community-based organizations should implement parent education programs that equip adults with age-appropriate language and approaches for discussing sexuality with their children. These programs should acknowledge cultural barriers while providing practical communication strategies, incorporate intergenerational dialogue sessions where parents and adolescents can discuss sensitive topics in facilitated environments, and develop family-oriented materials that support home-based discussions. This recommendation directly addresses the finding that cultural taboos prevent effective family communication about sexual health.

6.4 Recommendation for Future Studies

Future research should examine the effectiveness of integrated intervention programs combining cultural, economic, and healthcare components in similar urban compounds, using mixed-methods approaches to evaluate both implementation processes and outcomes.

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APPENDICES

Appendix i: Questionnaire for Adolescent

Dear Participant,

You are invited to participate in a research study titled "Investigating the Socio-cultural and Economic Factors Influencing Adolescent Pregnancy in Kafue, Zambia: A Case Study of Zambia Compound." This study is being conducted by Annie Samara Banda from the University of Lusaka.

The purpose of this research is to understand the factors contributing to adolescent pregnancy in our community. Your participation will involve completing a questionnaire that should take approximately 10 minutes. Your responses will be confidential and used solely for research purposes.

Your participation is voluntary, and you may withdraw at any time without penalty. If you have any questions or concerns, please contact +260979040245

Thank you for your valuable contribution to this important research.

Sincerely,

Annie Samara Banda

Demographic Characteristics Questions:

1. What is your age?
 - a) 15-16 years
 - b) 17-18 years
 - c) 19 years
2. What is your highest level of education?
 - a) No formal education
 - b) Primary school
 - c) Secondary school
 - d) Tertiary education
3. What is your current occupation?
 - a) Student
 - b) Employed (full-time or part-time)
 - c) Self-employed
 - d) Unemployed
 - e) Other (please specify): _____
4. What is your marital status?
 - a) Single
 - b) Married
 - c) Cohabiting
 - d) Separated/Divorced
 - e) Widowed
5. How many children do you have, if any?
 - a) None
 - b) 1
 - c) 2
 - d) 3 or more

How do cultural norms and practices influence adolescent sexual behavior in Zambia Compound?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Please tick the number that best reflects the extent to which you are agree with the statements below.

Statement	1	2	3	4	5
In our community, it is acceptable for adolescents to engage in sexual activities.					
Traditional initiation ceremonies encourage early sexual debut among adolescents.					
Parents in our community openly discuss sexual health with their adolescent children.					
Early marriage is seen as a way to prevent premarital pregnancy in our community.					
Religious beliefs in our community discourage the use of contraceptives among adolescents.					
Peer pressure plays a significant role in adolescent sexual behavior in our community.					
Cultural norms in our community prioritize male sexual pleasure over female sexual health.					
There is a stigma associated with seeking sexual health information in our community.					
Traditional healers are often consulted for sexual health issues instead of medical professionals.					
Gender roles in our community limit girls' ability to negotiate safe sexual practices.					

How do economic conditions impact adolescent pregnancy rates in Zambia Compound?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Please tick the number that best reflects the extent to which you are agree with the statements below.

Statement	1	2	3	4	5
Poverty in our community increases the likelihood of adolescent pregnancy.					
Limited job opportunities lead some adolescents to engage in transactional sex.					
The cost of contraceptives is a barrier to their use among adolescents in our community.					
Adolescents from wealthier families are less likely to experience early pregnancy.					
Economic hardship forces some adolescents to drop out of school, increasing their risk of pregnancy.					
Some adolescents view early pregnancy as a means to secure financial support from partners.					
Economic pressures lead some parents to encourage early marriage for their adolescent daughters.					
Lack of recreational facilities in our community contributes to risky sexual behavior among adolescents.					
Economic empowerment programs for adolescents can help reduce early pregnancy rates.					

To what extent do peer pressure and social networks influence adolescent sexual behaviour and pregnancy risk among adolescents in Zambia Compound?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Please tick the number that best reflects the extent to which you are agree with the statements below.

Statement	1	2	3	4	5
My friends often pressure me to engage in sexual activities nowadays.					
Engaging in sexual relationships will make me more popular among peers.					
My social media friends encourage me to explore sexual relationships freely.					
Being sexually active helps me maintain my status in peer groups.					
I feel excluded from my friend group when I refuse sexual advances.					
My friends share their sexual experiences, which influences my personal decisions.					
Social media content makes me feel pressure to be sexually active.					
My friends criticize me when I choose to abstain from sex.					
Having multiple sexual partners increases my popularity among my peer group.					
My friends encourage me to engage in unprotected sex for pleasure.					
Social media platforms expose me to sexually explicit content regularly today.					
My peers mock those who have not experienced sexual relationships yet.					

What is the level of accessibility and utilisation of sexual and reproductive health services for adolescents in Zambia Compound?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Please tick the number that best reflects the extent to which you are agree with the statements below.

Statement	1	2	3	4	5
Health facilities in my community are within walking distance for me.					
Healthcare workers treat adolescents with respect when seeking reproductive services here.					
The clinic provides private spaces for discussing sexual health concerns freely.					
Sexual health services are available at convenient times for young people.					
I can easily obtain contraceptives from local health facilities when needed.					
Healthcare providers maintain confidentiality when discussing my sexual health concerns here.					
The cost of accessing sexual health services is affordable for me.					
Information about sexual health services is readily available in my community.					
Youth-friendly corners at health facilities make me feel comfortable seeking services.					
Healthcare workers provide clear explanations about sexual and reproductive health issues.					
My culture allows me to seek sexual health services without shame.					
The waiting time for sexual health services is reasonable at facilities.					
I receive adequate counselling about contraceptive options at health facilities here.					
Local health facilities provide comprehensive sexual and reproductive health education regularly.					

Appendix ii: Interview Guide for Parents or Guardians:

Time of Interview:

Date of Interview:

Place:

Interviewer:

Thank you for agreeing to participate in this study on adolescent pregnancy in Zambia Compound. As a parent or guardian, your perspective is invaluable in understanding the factors that influence adolescent sexual behavior and pregnancy rates in our community. This interview will cover topics related to cultural norms, economic conditions, and access to health services. Please feel free to share your honest thoughts and experiences. Your responses will be kept confidential and used solely for research purposes.

How do cultural norms and practices influence adolescent sexual behavior in Zambia Compound?

1. How do you discuss sexuality and reproductive health with your adolescent children?
2. What traditional practices or beliefs in our community influence adolescent sexual behavior?
3. How do you think peer influence affects adolescent sexual behavior in our community?

How do economic conditions impact adolescent pregnancy rates in Zambia Compound?

1. How do you think poverty affects adolescent pregnancy rates in our community?
2. What economic challenges do families face in supporting their adolescent children's education and health needs?
3. How do you think job opportunities (or lack thereof) for young people influence adolescent pregnancy rates?

What is the level of access to sexual and reproductive health services for adolescents in Zambia Compound?

1. What are your views on adolescents accessing sexual and reproductive health services?
2. What barriers do you think adolescents face in accessing these services in our community?
3. How comfortable are you with your adolescent children accessing sexual and reproductive health services?

Appendix iii: Interview Guide for Community Leaders

Time of Interview:

Date of Interview:

Place:

Interviewer:

Welcome, and thank you for your participation in this important research on adolescent pregnancy in Zambia Compound. As a community leader, your insights are crucial in understanding the broader social and cultural context of this issue. We will be discussing how cultural norms, economic conditions, and access to health services affect adolescent sexual behavior and pregnancy rates in our community. Your expertise and knowledge of the community will greatly contribute to developing effective strategies to address this challenge. Please be assured that your responses will be treated with utmost confidentiality.

How do cultural norms and practices influence adolescent sexual behavior in Zambia Compound?

1. What cultural practices in our community do you think influence adolescent sexual behavior?
2. How does the community view adolescent sexual activity and early pregnancy?
3. What role do traditional leaders play in shaping attitudes towards adolescent sexuality?

How do economic conditions impact adolescent pregnancy rates in Zambia Compound?

1. How does the economic situation in our community affect adolescent pregnancy rates?
2. What economic initiatives exist to support adolescents and prevent early pregnancy?
3. How do you think improving economic opportunities could help reduce adolescent pregnancy rates?

What is the level of access to sexual and reproductive health services for adolescents in Zambia Compound?

1. What sexual and reproductive health services are available for adolescents in our community?
2. What community initiatives exist to improve adolescents' access to these services?
3. How does the community support or hinder adolescents' access to sexual and reproductive health information and services?

Appendix iv: Interview Guide for Healthcare Providers

Time of Interview:

Date of Interview:

Place:

Interviewer:

Thank you for taking the time to participate in this study on adolescent pregnancy in Zambia Compound. As a healthcare provider, your professional experience and observations are essential to understanding the health-related aspects of this issue. We will be exploring how cultural norms, economic conditions, and access to services influence adolescent sexual behavior and pregnancy rates. Your insights will be invaluable in identifying barriers to care and potential improvements in service delivery. Please know that your responses will be kept confidential and used only for the purposes of this research.

How do cultural norms and practices influence adolescent sexual behavior in Zambia Compound?

1. In your experience, how do cultural norms affect adolescents' willingness to seek sexual and reproductive health services?
2. What cultural barriers do you encounter when providing sexual health education to adolescents?
3. How do you address cultural sensitivities when discussing sexual health with adolescents?

How do economic conditions impact adolescent pregnancy rates in Zambia Compound?

1. How do you see economic factors influencing adolescents' sexual behavior and pregnancy rates?
2. What economic barriers do adolescents face in accessing contraceptives and other sexual health services?
3. How do economic conditions affect adolescents' ability to make informed decisions about their sexual and reproductive health?

What is the level of access to sexual and reproductive health services for adolescents in Zambia Compound?

1. What sexual and reproductive health services are currently available for adolescents in this facility?
2. What challenges do you face in providing youth-friendly sexual and reproductive health services?
3. How do you ensure confidentiality and privacy for adolescents seeking sexual health services?

Appendix v: Plagiarism Report



5.19% SIMILARITY OVERALL **13.87%** POTENTIALLY AI SCANNED ON: 12 JAN 2025, 10:54 AM

Similarity report

Your text is highlighted according to the matched content in the results above.

● CHANGED TEXT
5.19%

AI Detector Results

Highlighted sentences with the lowest perplexity, most likely generated by AI.

● LIKELY AI
13.87%

● HIGHLY LIKELY AI
0.00%

Report #24400001

1 3 4 CHAPTER ONE: INTRODUCTION 1.0 Introduction This study examined the effects of socio-cultural and economic factors on the adolescent pregnancy by using Kafue, Zambia, as case study, with a specific focus on Zambia Compound (ZC). Development of a young person's pregnancy is one of the most significant health and social issues in Zambia, which comes with a whole lot of problems. The study was intended to give a clear demonstration of the strong contributions made by cultural norms, social practices, and economic status as major factors in the high rate of teenage pregnancy in the urban community. Through such a comprehensive review, the study expected that challenges relating to this phenomenon would be adequately addressed. 1.1 Background of the Study It is a fact that adolescent pregnancy constitutes a diachronic public health and socio-economic challenge in Sub-Saharan Africa, with Zambia having the highest prevalence. As per the newest estimates released by WHO, 29% of adolescent girls of ages 15-19 in Zambia had a child (Whiteson, 2024). Early childbearing and pregnancy are major threats to the health, education, through pregnancies (Oduor & Kithuka, 2022). Customs and traditions shape the sexual activity of teenagers and have a major effect on their reproductive outcomes (Whiteson, 2024). In particular, in some areas of Zambia, traditional ceremonies are held where young girls are initiated into adulthood, these 1 ceremonies