

Socio-Cultural Factors Influencing the Uptake of Modern Contraceptive Among Women of Reproductive Age (15 - 49 Years) in Kawama and Mukobeko Township Area, Kabwe District, Zambia

Monde Sooka^{1*}, Nsala Mauzu²

¹Master of Social Work Student at Mulungushi University, School of Social Sciences, Department of Social Development Studies, Kabwe, Zambia

²Mulungushi University, School of Social Sciences, Department of Social Development Studies, Kabwe, Zambia

*Corresponding Author

DOI: <https://doi.org/10.47772/IJRISS.2026.100600922>

Received: 21 June 2025; Accepted: 26 June 2026; Published: 08 July 2026

ABSTRACT

Background: Modern contraceptives are essential for improving maternal health outcomes, reducing unintended pregnancies, promoting child spacing, and lowering maternal mortality. Despite increased awareness and expansion of family planning services in Zambia, uptake of modern contraceptives remains inconsistent in many peri-urban communities due to persistent socio-cultural barriers. This study investigated socio-cultural factors influencing the uptake of modern contraceptives among women of reproductive age (15-49 years) in Kawama and Mukobeko townships of Kabwe District, Zambia.

Methods: The study employed a convergent parallel mixed-methods design integrating quantitative and qualitative approaches. Quantitative data were collected from 205 women of reproductive age using structured questionnaires, while qualitative data were obtained through two focus group discussions and ten key informant interviews involving healthcare workers, community leaders, religious leaders, and male partners. Quantitative data were analysed using SPSS version 22 through descriptive statistics, chi-square tests, and multivariable logistic regression. Qualitative data were analysed thematically using Braun and Clarke's six-step framework supported by Nvivo 15.

Results: Findings revealed high awareness of modern contraceptives among respondents (85.9%). However, qualitative findings demonstrated that awareness did not consistently translate into uptake because of persistent myths and misconceptions surrounding infertility, cancer, prolonged bleeding, and perceived side effects. Bivariate analysis showed statistically significant associations between contraceptive uptake and age ($\chi^2=21.34$, $p=0.001$), marital status ($\chi^2=19.765$, $p=0.001$), occupation ($\chi^2=11.11$, $p=0.049$), and parity ($\chi^2=33.326$, $p=0.001$). Multivariable logistic regression identified age as the only statistically significant socio-demographic predictor of contraceptive uptake (AOR=0.529, 95% CI: 0.345–0.811, $p=0.004$). Socio-cultural regression analysis further showed that women's autonomy in family planning decisions, fear of social judgement, community acceptance, and family approval significantly influenced contraceptive uptake. Qualitative findings revealed that cultural expectations regarding fertility, religious teachings, gender power relations, stigma, and partner dominance strongly shaped reproductive decision-making.

Conclusion: The study concludes that although awareness of modern contraceptives was high, uptake remained constrained by socio-cultural barriers embedded within family and community structures. Improving contraceptive uptake in peri-urban communities requires integrated interventions focusing on community education, male involvement, women's empowerment, stigma reduction, and culturally sensitive reproductive health programming.

Keywords: Contraceptive uptake, modern contraceptives, peri-urban communities, socio-cultural factors, women of reproductive age

BACKGROUND TO THE STUDY

Modern contraceptives are widely recognised as critical public health interventions for improving maternal and child health outcomes through prevention of unintended pregnancies, reduction of unsafe abortions, and promotion of healthy birth spacing. Access to family planning services allows women and couples to make informed reproductive decisions regarding the timing and number of children. Family planning has consequently become an important component of global reproductive health programmes and a key strategy for achieving Sustainable Development Goal 3, particularly Target 3.7, which seeks universal access to sexual and reproductive healthcare services by 2030.

Globally, the use of modern contraceptives has increased substantially over the past three decades. According to the United Nations Department of Economic and Social Affairs (2022), approximately 874 million women of reproductive age were using modern contraceptives compared to 467 million in 1990. Despite this progress, nearly 164 million women who wish to delay or avoid pregnancy are not using any contraceptive method, demonstrating persistent unmet need for family planning services. The burden remains disproportionately high in Sub-Saharan Africa (SSA), where contraceptive prevalence rates continue to lag behind global averages despite high fertility rates and increasing investment in reproductive health programmes.

Evidence from SSA indicates that contraceptive uptake is influenced not only by service availability but also by socio-cultural and gender-related factors. The African Population and Health Research Center (2021) reported that modern contraceptive prevalence among married women in SSA remains below 30%, compared to the global average exceeding 60%. Studies across SSA consistently identify myths, misinformation, gender inequalities, and cultural expectations as major barriers to contraceptive use. Bolarinwa et al. (2021) found that contraceptive uptake was strongly associated with women's autonomy, relationship dynamics, and socio-economic status across 26 SSA countries. Similarly, Adongo (2020) observed that fertility in many African societies is associated with social prestige, womanhood, and divine blessing, thereby discouraging contraceptive utilisation.

Research from several African countries further demonstrates that misconceptions regarding infertility, cancer, and side effects continue to influence reproductive decisions. Eshak (2020) found that many women in Egypt believed that oral contraceptives cause cancer and that intrauterine devices migrate within the body. In Ethiopia, Gebeyehu et al. (2018) reported that spousal disapproval, limited female autonomy, and fear of marital conflict significantly reduced uptake of long-acting contraceptive methods. These findings suggest that contraceptive behaviour is shaped by complex interactions between personal beliefs, social norms, and gender relations.

In Zambia, family planning remains a priority within national reproductive health programmes. According to the Zambia Demographic and Health Survey (2024), approximately 53% of women aged 15-49 years currently use modern contraceptives, while prevalence among married women stands at 55%. Injectables and implants remain the most commonly used methods. Despite progress in contraceptive coverage, uptake remains lower in peri-urban and rural communities where cultural norms, religious beliefs, myths, and gender inequalities continue to limit women's reproductive autonomy. Mutombo and Bakibinga (2018) reported that misconceptions regarding infertility and side effects remain widespread barriers to contraceptive use in Zambia. Kazibwe et al. (2024) further demonstrated persistent inequalities in contraceptive utilisation based on education and socio-economic status.

Existing Zambian studies have largely focused on adolescents, health system barriers, and urban populations, with limited attention given to community-level socio-cultural dynamics in peri-urban settings. Chola et al. (2023) found that adolescent girls in Zambia frequently experienced judgemental attitudes from healthcare providers, confidentiality concerns, and restricted contraceptive choices. In Kabwe District specifically, Silumbwe et al. (2018) identified myths, rumours, and religious influences as major barriers to family planning utilisation despite widespread awareness of contraceptive methods. However, there remains limited evidence examining how community attitudes, gender relations, religious beliefs, and informal social structures

collectively influence contraceptive uptake among women in peri-urban communities such as Kawama and Mukobeko.

This study therefore sought to investigate socio-cultural factors influencing the uptake of modern contraceptives among women of reproductive age in Kawama and Mukobeko townships of Kabwe District, Zambia. The study was guided by the Health Belief Model and the Theory of Planned Behaviour. The Health Belief Model explains how perceived susceptibility, benefits, barriers, and severity influence health behaviour, while the Theory of Planned Behaviour emphasises the role of attitudes, subjective norms, and perceived behavioural control in shaping behavioural intentions. Together, the two theories provide a comprehensive framework for understanding how individual perceptions and broader socio-cultural influences shape contraceptive behaviour within peri-urban communities.

The study contributes to existing literature by generating context-specific evidence on socio-cultural determinants of contraceptive uptake in peri-urban Zambia. The findings are expected to inform culturally sensitive reproductive health interventions, strengthen district-level family planning programming, and contribute to policy strategies aimed at improving reproductive health outcomes among women of reproductive age.

MATERIALS AND METHODS

Research Design

The study employed a convergent parallel mixed-methods research design in which quantitative and qualitative data were collected concurrently, analyzed independently, and integrated during interpretation. The design was appropriate because contraceptive uptake is a multidimensional social and behavioural phenomenon requiring both statistical measurement and contextual understanding. Quantitative methods enabled the measurement of awareness levels, prevalence of contraceptive uptake, and associations between socio-cultural variables and contraceptive use, while qualitative methods explored participants' lived experiences, beliefs, perceptions, and community norms influencing reproductive decision-making. The integration of the two approaches enhanced methodological triangulation, strengthened validity, and provided a comprehensive understanding of socio-cultural influences affecting contraceptive uptake.

Study Site

The study was conducted in Kawama and Mukobeko Townships in Kabwe District, Central Province, Zambia. The two peri-urban communities were purposively selected because they exhibit socio-cultural characteristics associated with low contraceptive uptake despite the availability of family planning services. The communities are served by public health facilities offering reproductive health and family planning services; however, traditional beliefs, religious influences, myths, misconceptions, and gender norms continue to shape reproductive behaviour. Their peri-urban setting provided an appropriate context for examining how socio-cultural dynamics influence contraceptive uptake among women of reproductive age.

Target Population

The target population comprised women of reproductive age (15-49 years) residing in Kawama and Mukobeko Townships for at least six months prior to data collection. The study focused on this population because women within this age group are the primary users and beneficiaries of modern contraceptive methods. The qualitative component additionally included key informants such as healthcare workers, community leaders, religious leaders, and male partners due to their influence on reproductive health decisions and community perceptions regarding contraceptive use.

Sample Size and Sampling Procedures

For the quantitative component, the sampling frame consisted of approximately 421 women of reproductive age. Using Yamane's (1967) formula at a 95% confidence level and 5% margin of error; where n represents the

sample size, N represents the population size, and e represents the acceptable margin of error. Therefore, a calculated sample size of 205 respondents was considered statistically adequate for the study as shown in the formula below.

$$n = \frac{N}{1 + N(e^2)} = \frac{421}{1 + 421(0.05^2)} = \frac{421}{1 + 421(0.0025)} = \frac{421}{1 + 1.0525} = \frac{421}{2.05257} = 205.12 = \mathbf{205}$$

Systematic random sampling was employed to select eligible participants from household listings in the two communities. This approach ensured that each eligible woman had an equal probability of selection, thereby minimizing selection bias and enhancing representativeness. For the qualitative component, purposive sampling was employed to select participants with relevant knowledge and experiences regarding contraceptive uptake. The qualitative sample comprised twenty participants for focus group discussions and ten key informants, including healthcare workers, religious leaders, male partners, and community leaders. Sampling continued until thematic saturation was achieved.

Data Collection Methods

Quantitative data were collected using structured questionnaires administered with the assistance of trained research assistants. The questionnaires contained closed-ended and Likert-scale questions designed to assess awareness, knowledge, utilisation of contraceptive methods, and socio-cultural factors influencing contraceptive uptake. Depending on participants' literacy levels, questionnaires were either self-administered or interviewer-administered. Qualitative data were collected through focus group discussions and key informant interviews using semi-structured interview guides. Focus group discussions explored collective community attitudes, perceptions, myths, misconceptions, and gender norms surrounding contraceptive use. Key informant interviews provided expert insights into cultural practices, religious influences, and health system factors affecting contraceptive uptake. All interviews and discussions were audio-recorded with participants' consent and supplemented by field notes.

Data Analysis and Interpretation

Quantitative data were analyzed using Statistical Package for Social Sciences (SPSS) version 22. Descriptive statistics including frequencies, percentages, means, and standard deviations were used to summarize the data. Inferential statistics were conducted using Pearson's Chi-square tests to examine associations between socio-demographic variables and contraceptive uptake. Multivariable logistic regression analysis was further employed to identify independent predictors of contraceptive uptake. Statistical significance was set at $p < 0.05$, with Adjusted Odds Ratios (AORs) and 95% confidence intervals used to determine the strength of associations. Qualitative data were analyzed using Braun and Clarke's (2006) six-step thematic analysis framework supported by Nvivo version 15. The analysis involved data familiarization, coding, theme generation, reviewing themes, defining themes, and report writing. Emerging themes focused on awareness, myths and misconceptions, cultural beliefs, religious influences, stigma, women's autonomy, and gender relations. Participant quotations were used to support thematic interpretation. Integration of quantitative and qualitative findings was conducted during interpretation to identify convergent, complementary, and divergent findings.

Ethical Considerations

Ethical approval for the study was obtained from the Mulungushi University Research Ethics Committee under approval number MU/DRI/REC/2026/43. Permission to conduct the study was also obtained from relevant local authorities and health facilities. Written informed consent was obtained from adult participants, while assent and parental consent were obtained for participants aged 15-17 years. Participation was voluntary, and respondents were informed of their right to withdraw at any stage without penalty. Confidentiality, anonymity, and privacy were strictly maintained throughout the study. The study further adhered to internationally accepted ethical principles governing research involving human participants.

Study Findings (Results)

Introduction

This section presents the findings on socio-cultural factors influencing the uptake of modern contraceptives among women of reproductive age (15-49 years) in Kawama and Mukobeko townships of Kabwe District, Zambia. Quantitative and qualitative findings are integrated to provide a comprehensive understanding of how socio-cultural norms, gender relations, religious beliefs, myths, stigma, and community perceptions shape contraceptive decision-making.

Socio-Demographic Characteristics of Respondents

The majority of respondents were aged between 20 and 39 years, representing the most sexually active and reproductive age groups. Women aged 20-24 years constituted the largest proportion (17.6%), while respondents aged 30-34 years and 35-39 years each represented 16.6% of the sample. Concerning the highest level of education, most respondents had attained secondary education (58.0%), while 22.0% had tertiary education.

Table 1: Background Characteristics of Respondents

Age	Frequency	Percentage	Education Level	Frequency	Percentage
15-19	15	7.3	No Formal Education	14	6.8%
20-24	36	17.6	Primary	27	13.2%
25-29	31	15.1	Secondary	119	58%
30-34	34	16.6	Tertiary	45	22%
35-39	34	16.6	Total	205	100
40-44	24	11.7			
45-49	31	15.1			
Total	205	100			

In addition, nearly half of the respondents were married (49.8%), and Christianity was the dominant religion (93.7%). The table below gives a summary of the respondents by marital status and religious affiliations.

Table 2: Distribution of Respondents by Marital Status and Religious Affiliation

Marital Status	Frequency	Percentage	Religion	Frequency	Percentage
Single	60	29.3	Christian	192	93.7
Married	102	49.8	Islam	12	5.8
Divorced	29	14.1	Other	1	0.5
Widowed	12	5.9	Total	205	100
Cohabiting	2	1			
Total	205	100			

Source: Field Data (2026)

In terms of occupation, housewives (25.9%) and businesswomen (23.9%) formed the largest occupational categories. Regarding parity, most respondents had between one and four children, with 38% reporting three to four children. The mean age category of respondents was 30-34 years (SD = 1.87), with a median age category of 30-34 years and a modal category of 20-24 years, suggesting concentration within early and middle reproductive ages. The table below gives a summary of the respondents by occupation and number of children.

Table 3: Distribution of Respondents by Occupation and Number of Children

Occupation	Frequency	Percentage	Number of Children	Frequency	Percentage
Housewife	53	25.9	None	30	14.6
Farmer	18	8.8	1-2	73	35.6

Businesswoman	49	23.9	3-4	78	38.0
Student	29	14	5 or more	24	11.7
Employed	36	17.6	Total	205	100
Other	20	9.8			
Total	205	100			

Measure of Central tendency (Age)	
Number of Respondents	205
Mean	30 -34
Median	30-34
Mode	20-24
Std. Deviation	1.873
Sum	847

Source: Field Data (2026)

Awareness and Uptake of Modern Contraceptives

Quantitative findings revealed high awareness of modern contraceptives among respondents, with 85.9% reporting awareness of at least one modern contraceptive method.

Table 4: Awareness of Modern Contraceptive Methods

Response	Frequency	Percentage
Yes	176	85.9
No	29	14.1
Total	205	100

Source: Field Data (2026)

In addition, the results in the table above revealed that (14.1%) respondents had utilised at least one modern contraceptive method.

Table 5: Current Uptake of Modern Contraceptives

Response	Frequency	Percentage
Yes	29	14.1
No	176	85.9
Total	205	100

Qualitative findings corroborated this result, as the participants demonstrated familiarity with several contraceptive methods including oral pills, injectables, condoms, implants, intrauterine devices (IUDs), and emergency contraceptives. Participants identified clinics, hospitals, pharmacies, chemists, peers, schools, churches, media platforms, and community outreach programs as key sources of reproductive health information. Health facilities were generally perceived as reliable information sources, whereas peer networks and informal community discussions were often associated with misinformation. One participant explained:

“Most women are aware and knowledgeable about family planning and they know the different methods of family planning.” (Participant 3, FGD, Mukobeko)

Despite high awareness, qualitative narratives revealed that knowledge alone did not consistently translate into contraceptive utilisation. Persistent fears relating to infertility, cancer, prolonged bleeding, and other perceived side effects continued to discourage uptake.

Another participant stated:

"I know various methods of contraceptives, though some women fear using them because of beliefs about infertility and birth defects." (Participant 3, FGD, Kawama)

These findings suggest a substantial disconnect between contraceptive awareness and actual utilisation, indicating that socio-cultural perceptions may outweigh informational exposure in shaping reproductive decisions.

Association Between Socio-Demographic Factors and Contraceptive Uptake

Bivariate analysis using Pearson's Chi-square test demonstrated statistically significant associations between modern contraceptive uptake and age, marital status, occupation, and parity ($p < 0.05$). Age was significantly associated with contraceptive uptake ($\chi^2(6) = 21.34$, $p = 0.001$). Similarly, marital status ($\chi^2(4) = 19.77$, $p = 0.001$), occupation ($\chi^2(5) = 11.11$, $p = 0.049$), and number of children ($\chi^2(3) = 33.33$, $p = 0.001$) were significantly related to contraceptive use. However, education level ($\chi^2(3) = 2.91$, $p = 0.406$) and religion ($\chi^2(2) = 2.29$, $p = 0.319$) were not statistically significant at the bivariate level.

Although marital status, occupation, educational attainment, and parity demonstrated associations at the bivariate level, these relationships lost statistical significance in the multivariable model. This indicates that contraceptive behaviour is shaped by more complex socio-cultural and interpersonal dynamics beyond demographic characteristics alone.

Table 6: Association between Socio-Demographic Factors and Modern Contraceptive Uptake among Women of Reproductive Age

Variable	Contraceptive uptake n (%)		Total	P - Value
	YES	NO	N(%)	Chi2
AGE				$\chi^2(6) = 21.34$, $p\text{-value} = 0.001$
15 - 19	7(3.4%)	8(3.9%)	15(7.3%)	
20 - 24	24(11.7%)	12(5.9%)	36(17.6%)	
25 - 29	27(13.2%)	4(2.0%)	31(15.1%)	
30 - 34	32(15.6%)	2(1.0%)	34(16.6%)	
35 - 39	33(16.1%)	1(0.5%)	34(16.6%)	
40 - 44	23(11.2%)	1(0.5%)	24(11.7%)	
45 - 49	30(14.6%)	1(0.5%)	31(15.1%)	
Total	176(85.9%)	29(14.1%)	205(100%)	
Education Level				$\chi^2(3) = 2.910$, $p\text{-value} = 0.406$
No formal education	14(6.8%)	0(0.0%)	14(6.8%)	
Primary	24(11.7%)	3(1.5%)	27(13.2%)	
Secondary	100(48.8%)	19(9.3%)	119(58.0%)	
Tertiary	38(18.5%)	7(3.4%)	45(22.0%)	
Total	176(85.9%)	29(14.1%)	205(100%)	
Marital Status				$\chi^2(4) = 19.765$, $p\text{-value} = 0.001$
Single	43(21.0%)	17(8.3%)	60(29.3%)	
Married	91(44.4%)	11(5.5%)	102(49.8%)	
Divorced	29(14.1%)	0(0%)	29(14.1%)	
Widowed	12(5.9%)	0(0%)	12(5.9%)	
Cohabiting	1(5.9%)	1(5.9%)	2(1.0%)	
Total	176(85.9%)	29(14.1%)	205(100%)	
Occupation				$\chi^2(5) = 11.11$, $p\text{-value} = 0.049$
Housewife	46(22.4%)	7(3.4%)	53(25.9%)	
Farmer	17(8.3%)	1(0.5%)	18(8.8%)	
Businesswoman	46(22.4%)	3(1.5%)	49(23.9%)	
Student	20(9.8%)	9(4.4%)	29(14.1%)	
Employed	31(15.1%)	5(2.4%)	36(17.6%)	
Other (Not Married)	16(7.8%)	4(2.0%)	20(9.8%)	

Total	176(85.9%)	29(14.1%)	205(100%)	
Religion				$\chi^2(2)=2.287$, p-value=0.319
Christianity	163(79.5%)	29(14.1%)	192(93.7%)	
Islam	12(5.9%)	0(0.0%)	12(5.9%)	
Other	1(0.5%)	0(0.0%)	1(0.5%)	
Total	176(85.9%)	29(14.1%)	205(100%)	
Number of children				$\chi^2(3)= 33.326$,p-value=0.001
None	16(7.8%)	14(6.8%)	30(14.6%)	
1 - 2	63(30.7%)	10(4.9%)	73(35.6%)	
3 - 4	74(36.1%)	4(2.0%)	78(38.0%)	
5 or more	23(11.2%)	1(0.5%)	24(11.7%)	
Total	176(85.6%)	29(14.1%)	205(100%)	

Source: Field Data (2026)

Multivariable logistic regression analysis further demonstrated that age was the only socio-demographic variable independently associated with contraceptive uptake after adjusting for confounding variables ($B = -0.636$, $p = 0.004$; AOR = 0.529; 95% CI: 0.345-0.811). The findings suggest that increasing age was associated with lower odds of modern contraceptive uptake.

Table 7: Multivariate Logistic Regression of Socio-Demographic Factors Associated With Uptake of Modern Contraceptives Among Women of Reproductive Age.

Variables	B	S.E.	Df	Sig.	AOR	95% C.I. for EXP(B)	
						Lower	Upper
Age	-0.636	0.218	1	0.004	0.529	0.345	0.811
Marital Status	-0.126	0.352	1	0.721	0.882	0.442	1.760
Education level	0.505	0.356	1	0.156	1.657	0.824	3.333
Occupation	0.017	0.153	1	0.909	1.018	0.754	1.373
Number of Children	-0.411	0.406	1	0.311	0.663	0.299	1.469

Source: Field Data (2026)

Qualitative Results

Qualitative findings reinforced these results by revealing that younger women were more exposed to reproductive health information and youth-oriented services, thereby increasing awareness and willingness to seek contraceptive services.

Women's Autonomy and Reproductive Decision-Making

Women's autonomy emerged as a critical determinant of contraceptive behaviour. The multivariable regression model showed that women's autonomy in family planning decision-making was significantly associated with contraceptive uptake ($B = -0.570$, $p = 0.005$; AOR = 0.566; 95% CI: 0.381-0.840).

Although the inverse statistical direction may reflect contextual and coding complexities, qualitative findings demonstrated that women with higher educational attainment and economic independence reported greater influence over reproductive decisions.

One participant stated:

"As a single person, I have the autonomy to make my own decisions about contraceptive use." (Participant 4, FGD, Kawama)

Another participant explained:

“From the time I obtained tertiary education and started earning my own money, I gained more influence in family planning decisions.” (Participant 6, FGD, Kawama)

However, married women frequently described limited reproductive autonomy due to male dominance, economic dependence, and cultural expectations.

“As a married woman, I always follow what my partner wants regarding family planning.” (Participant 10, FGD, Kawama)

From the presentation above, the findings indicate that women’s reproductive autonomy remains embedded within broader gender and cultural power structures.

Cultural and Religious Influences on Contraceptive Uptake

Qualitative findings showed that cultural norms surrounding fertility and family size strongly influenced contraceptive behaviour. Larger families were commonly associated with prestige, social recognition, and fulfillment of traditional expectations of womanhood.

One participant stated:

“Culturally, women are expected to have many children.” (Participant 6, FGD, Mukobeko)

Participants further emphasized that reproductive decisions were frequently influenced by husbands, elders, and extended family members.

“In some cultures, men decide how many children a woman should have.” (Participant 6, FGD, Mukobeko)

Quantitative findings similarly showed that the perception that elders or family members should approve contraceptive use was significantly associated with uptake ($B = 0.448$, $p = 0.022$; $AOR = 1.565$; 95% CI: 1.067-2.297).

Religious influences emerged more strongly within qualitative narratives than quantitative findings. While statistical analysis found no significant association between religion and contraceptive uptake, participants reported that certain religious teachings discouraged artificial contraception, whereas others supported child spacing.

A healthcare worker noted:

“Catholics often discourage artificial contraception.” (Healthcare Worker, Kawama)

From the presentations above, these results suggest that religious teachings influence contraceptive attitudes indirectly through community norms and moral expectations rather than through formal religious affiliation alone.

Myths, Misconceptions, and Perceived Side Effects

Myths and misconceptions emerged as major barriers to contraceptive uptake despite widespread awareness of family planning methods. Participants associated modern contraceptives with infertility, cancer, deformities, prolonged menstruation, severe headaches, reduced sexual pleasure, and weight changes.

A healthcare worker explained:

“Most people believe that contraceptives cause infertility, cancer, and severe health problems.” (Healthcare Worker, Mukobeko)

Another participant reported:

“Some women avoid using the loop because they believe children will be born with deformities.” (Participant 2, FGD, Kawama)

Fear of side effects often resulted in discontinuation, non-use, or switching between methods.

“Most women stop using contraceptives because of prolonged bleeding and severe headaches.” (Participant 7, FGD, Mukobeko)

From the presentations above, these findings demonstrate that misconceptions remain deeply embedded within community perceptions and continue to undermine contraceptive uptake.

3.7 Stigma, Social Judgement, and Community Perceptions

Community stigma and social judgement significantly shaped contraceptive behaviour. Quantitative findings revealed that fear of being judged for using contraceptives was significantly associated with contraceptive uptake ($B = 0.476$, $p = 0.048$; $AOR = 1.610$; 95% CI: 1.003-2.583).

Qualitative findings further revealed that unmarried women and adolescents who sought contraceptive services were frequently labelled immoral or promiscuous.

“Some women who use contraceptives are viewed as prostitutes, especially unmarried women.” (Healthcare Worker, Kawama)

Participants explained that fear of social judgement encouraged secrecy and discouraged open discussion regarding reproductive health.

From the presentations above, these results suggest that contraceptive behaviour is strongly shaped by community perceptions and social norms.

Health Systems and Service Delivery Experiences

Participants acknowledged the role of healthcare workers in providing contraceptive information and counselling. However, concerns regarding negative provider attitudes, confidentiality concerns, and limited youth-friendly services were frequently reported.

A community leader stated:

“I have seen many young people avoid family planning services because of negative attitudes from health workers.” (Community Leader)

Although family planning services were available within the study communities, social and institutional barriers reduced service utilisation, particularly among adolescents and unmarried women.

DISCUSSION AND INTERPRETATION OF FINDINGS

The study examined socio-cultural factors influencing the uptake of modern contraceptives among women of reproductive age in Kawama and Mukobeko townships of Kabwe District, Zambia. Findings demonstrated that although awareness of modern contraceptives was generally high, socio-cultural barriers continued to significantly influence uptake and reproductive decision-making.

Awareness of modern contraceptives

The study revealed that 85.9% of respondents were aware of modern contraceptive methods, while qualitative findings showed that most participants could identify common methods such as pills, injectables, condoms, implants, and intrauterine devices. These findings are consistent with Sedgh and Hussain (2020), who reported relatively high contraceptive awareness across many Sub-Saharan African countries. However, the current study

further demonstrated that awareness alone did not guarantee utilisation because many women associated contraceptives with infertility, cancer, prolonged bleeding, and other perceived side effects. This finding supports the Health Belief Model, which argues that perceived barriers may discourage individuals from engaging in health-promoting behaviours even when awareness is high. In the current study, fear-based beliefs significantly influenced contraceptive decisions despite high awareness levels.

Social Demographic Factors

Bivariate analysis demonstrated statistically significant associations between contraceptive uptake and age, marital status, occupation, and parity. However, multivariable logistic regression identified age as the only statistically significant socio-demographic predictor of contraceptive uptake (AOR=0.529, $p=0.004$). Younger women appeared more likely to utilise contraceptives, potentially due to greater exposure to reproductive health education and youth-friendly services. Similar findings were reported by Mandiwa (2018) in Malawi, where younger women with exposure to family planning messages demonstrated higher contraceptive utilisation. The findings align with the Theory of Planned Behaviour, particularly the concept of perceived behavioural control, whereby access to information and supportive services enhances behavioural intention (Ajzen, 1991).

Women's autonomy and decision making

Women's autonomy emerged as an important determinant of contraceptive uptake. Qualitative findings indicated that women with higher educational attainment and economic independence reported greater influence over reproductive decisions. However, quantitative findings showed an inverse relationship between perceived autonomy and contraceptive uptake. This contradiction suggests that reproductive decision-making within peri-urban communities remains embedded within broader cultural and relational structures. Even where women possess decision-making capacity, partner influence, cultural expectations, and family approval may continue to shape contraceptive behaviour. Similar observations were reported by Bolarinwa et al. (2021), who found that women's reproductive autonomy often interacts with social and economic inequalities. This means that even though educated and economically independent women reported greater decision-making power, reproductive choices continued to be negotiated within patriarchal household structures. This finding aligns with the Theory of Planned Behaviour, particularly the role of subjective norms and perceived behavioural control in shaping behavioural intentions (Ajzen, 1991).

Cultural and Religious factors

Cultural norms and religious beliefs also emerged as major influences on contraceptive behaviour. Participants associated large family sizes with prestige, social recognition, and fulfillment of cultural expectations regarding womanhood and marriage. Reproductive decisions were often collective rather than individual, involving male partners, elders, and extended family networks. This finding underscores the importance of community-centred family planning interventions that engage influential social actors. Religious teachings were reported to both encourage child spacing and discourage artificial contraception depending on doctrinal interpretation. Although religion was not statistically significant in the quantitative model, qualitative findings demonstrated that religious narratives influenced attitudes towards fertility, morality, and contraceptive use. These findings support the Theory of Planned Behaviour, particularly the role of subjective norms in shaping behavioural intentions (Ajzen, 1991).

Stigma, Social judgement and Community Perceptions

The study further identified stigma, myths, and community judgement as persistent barriers to contraceptive utilisation. Unmarried women using contraceptives were frequently perceived as promiscuous, leading many women to access services secretly. Myths surrounding infertility, cancer, and birth defects remained widespread despite high awareness levels. These findings are consistent with Mutombo and Bakibinga (2018) and Eshak (2020), who similarly identified misinformation and fear-based beliefs as major barriers to contraceptive uptake. Such misconceptions increase perceived risks associated with contraceptive use and reinforce community resistance toward family planning programmes. This means that the perceived stigma often encouraged secrecy and discouraged open reproductive health discussions.

Although family planning services were available within the study communities, participants highlighted several health system barriers including judgemental provider attitudes, confidentiality concerns, and inadequate youth-friendly services. These findings correspond with Chola et al. (2023), who reported similar experiences among adolescent girls accessing contraceptive services in Zambia. The findings demonstrate that service availability alone is insufficient to improve contraceptive uptake without ensuring culturally sensitive, acceptable, and youth-responsive healthcare delivery systems. Although health facilities provided family planning services, provider attitudes and lack of youth-friendly services discouraged access among vulnerable groups.

From the discussions above, the findings demonstrate that contraceptive uptake in peri-urban communities is shaped by complex interactions between individual perceptions, gender dynamics, cultural expectations, community attitudes, and health system factors. Improving uptake therefore requires integrated interventions that combine reproductive health education, women's empowerment, male involvement, community engagement, stigma reduction, and culturally sensitive family planning programming.

CONCLUSION

The study demonstrated that awareness and knowledge of modern contraceptives were generally high among respondents, with most participants identifying commonly used methods such as injectables, pills, condoms, implants, and intrauterine devices. Despite this high awareness, uptake remained constrained by socio-cultural factors including myths and misconceptions, cultural expectations regarding fertility, religious influences, stigma, gender inequalities, and limited decision-making autonomy among women. Quantitative findings revealed significant associations between age, marital status, occupation, parity, and contraceptive uptake, although age emerged as the only statistically significant predictor in the multivariable logistic regression model (AOR = 0.529; $p = 0.004$). The study further established that women's autonomy, fear of social judgement, comfort in accessing family planning services, and family approval significantly influenced contraceptive behaviour. Qualitative findings reinforced these results by revealing that reproductive decisions were strongly shaped by cultural norms, religious teachings, community perceptions, and partner influence. The study concludes that contraceptive uptake in peri-urban communities is influenced more by socio-cultural dynamics than by service availability alone. Therefore, improving reproductive health outcomes requires integrated interventions combining community engagement, behavioural change communication, male involvement, women's empowerment, culturally sensitive programming, and strengthened health systems.

RECOMMENDATIONS

The study recommends that the Ministry of Health, in collaboration with community stakeholders, religious institutions, and civil society organizations, should strengthen community-based reproductive health education programs aimed at dispelling myths and misconceptions regarding modern contraceptives. Community sensitization initiatives should focus on addressing fears relating to infertility, cancer, side effects, and social stigma through culturally appropriate communication strategies. Health facilities should expand youth-friendly and confidential family planning services while promoting respectful and non-judgmental healthcare delivery. The study further recommends integrating male involvement, community leadership participation, and religious engagement into reproductive health programming to improve community acceptance of family planning services. Women's empowerment initiatives focusing on education, economic independence, and reproductive decision-making autonomy should also be strengthened. In addition, policymakers should incorporate socio-cultural barrier reduction strategies into national family planning policies and community health outreach programs. The study contributes to knowledge by providing context-specific evidence on how socio-cultural dynamics influence contraceptive uptake within peri-urban Zambian communities. The integration of quantitative and qualitative findings offers a comprehensive understanding of how cultural norms, gender relations, myths, and religious beliefs interact to shape reproductive health behaviour. The findings contribute to the growing body of reproductive health literature in Sub-Saharan Africa and provide practical insights for culturally responsive family planning interventions.

Limitations of the Study

The study faced several limitations that may have influenced the findings. First, the relatively small sample size may have limited the statistical generalizability of the quantitative findings. However, the use of a mixed-

methods approach strengthened the credibility of the results through triangulation of quantitative and qualitative evidence. Secondly, cultural sensitivity surrounding reproductive health and contraceptive use may have resulted in socially desirable responses, particularly during interviews and focus group discussions. This challenge was minimized by assuring confidentiality, using culturally sensitive language, and employing trained female interviewers. The study was also limited by financial and time constraints because it was self-sponsored. In addition, the findings are context-specific to Kawama and Mukobeko Townships and may not be fully generalizable to other settings with different socio-cultural characteristics. Despite these limitations, the study provides valuable insights into reproductive health behaviour within peri-urban communities. Future studies should consider larger sample sizes and longitudinal research designs to examine changes in contraceptive attitudes and behaviour over time. Further research should also explore the role of male involvement, digital health communication, and adolescent reproductive health interventions in improving contraceptive uptake within peri-urban and rural communities.

About The Authors (Biography)

Monde Sooka

Ms Monde Sooka holds a Bachelor of Social Work from the University of Zambia and is currently pursuing a Master's Degree in Social Work from Mulungushi University. She has over 17 years' professional experience working with both Local and International NGOs. Her experience spans project management and administration, sub grant management, stakeholder engagement, monitoring & evaluation & learning (MEL) and risk management. Her technical experience includes economic strengthening programming, enterprise development & savings group facilitation, case management, community mobilization & development, qualitative and quantitative research, capacity building and advocacy. She has worked extensively in HIV prevention, care, treatment and support, impact mitigation, human rights, gender-based violence prevention & response, child protection, social protection & support to orphans & vulnerable children (OVC) Throughout her career, she has supported the successful implementation of multi donor-funded projects, including initiatives funded by the World Bank, Global Funds and USAID. Her work contributed to strengthening health and community systems, improving service delivery and supporting the wellbeing of vulnerable populations.

Email: mondesooka@gmail.com

Nsala Mauzu

Ms Nsala Mauzu holds a Bachelor of Social Work degree and a Master of Social Work degree from Mulungushi University, Zambia. She also holds a Diploma in Teaching Methodology from the University of Lusaka and a Certificate in Project Management. She is currently a Full-time Lecturer in the Department of Social Development Studies (SDS) under the School of Social Sciences at Mulungushi University, Zambia, where she teaches Social Work courses. She has experience in teaching, research, community development, counselling, and social work practice. Her academic and professional interests span social work practice, community development, social policy, social welfare, research methods, project planning and management, counselling, poverty reduction, gender and development, child welfare, and contemporary social issues. She is particularly interested in evidence-based interventions that enhance community well-being, social inclusion, and sustainable development.

Email: nsalamauzu@gmail.com

REFERENCES

1. Abeid, R.A., Sumari, E.I., Qin, C., Lyimo, A.A. and Luttaay, G.A. (2022). 'Uptake of modern contraceptives among women of reproductive age in Chake District'. PLOS ONE, 17(6), pp. 1-16.
2. Adongo, P. (2020). 'Cultural perceptions and reproductive decision-making among women in Sub-Saharan Africa'. African Journal of Reproductive Health, 24(3), pp. 45-57.
3. African Population and Health Research Center [APHRC] (2021). Barriers to modern contraceptive use in Africa. Nairobi: African Population and Health Research Center Press.
4. Ajzen, I. (1991). 'The theory of planned behavior'. Organizational Behavior and Human Decision Processes, 50(2), pp. 179-211.

5. Barden-O'Fallon, J. and Speizer, I.S. (2011). 'What differentiates method stoppers from switchers? Contraceptive discontinuation and switching among Honduran women'. *International Perspectives on Sexual and Reproductive Health*, 37(1), pp. 16-23.
6. Bolarinwa, O.A., Nwagbara, U.I., Okyere, J., Ahinkorah, B.O., Seidu, A.-A. and Ameyaw, E.K. (2021). 'Prevalence and predictors of long-acting reversible contraceptive use among sexually active women in 26 Sub-Saharan African countries'. *International Health*, 14(5), pp. 492-500.
7. Braun, V. and Clarke, V. (2006). *Thematic analysis: A practical guide*. London: Sage Publications.
8. Bryman, A. (2016). *Social research methods*, 5th edition. Oxford: Oxford University Press.
9. Chola, M., Hlongwana, K. and Ginindza, T.G. (2023). 'Understanding adolescent girls' experiences with accessing and using contraceptives in Zambia'. *BMC Public Health*, 23(1), Article 2149.
10. Eshak, E. (2020). 'Myths about modern and traditional contraceptives held by women in Minia, Upper Egypt'. *Eastern Mediterranean Health Journal*, 26(4), pp. 417-425.
11. Field, A. (2018). *Discovering statistics using IBM SPSS statistics*, 5th edition. London: Sage Publications.
12. Gebeyehu, A., Asnake, M., Dibaba, Y., Setegn, T., Yirga, M., Teklu, A.M. and Tura, G. (2018). 'Barriers to utilisation of long acting reversible and permanent contraceptive methods in Ethiopia: A systematic review'. *Ethiopian Journal of Reproductive Health*, 10(3), pp. 1-24.
13. Kazibwe, J., Masiye, F., Klingberg Allvin, M., Ekman, B. and Sundewall, J. (2024). 'Inequality in modern contraceptive use and unmet need for contraception among women of reproductive age in Zambia: A trend and decomposition analysis, 2007-2018'. *Reproductive Health*, 21(1), Article 181.
14. Kvale, S. and Brinkmann, S. (2015). *Interviews: Learning the craft of qualitative research interviewing*, 3rd edition. Thousand Oaks, CA: Sage Publications.
15. Mutombo, N. and Bakibinga, P. (2018). 'Understanding barriers to contraceptive use in Zambia'. *BMC Public Health*, 18(1), pp. 137-148.
16. Polit, D.F. and Beck, C.T. (2021). *Nursing research: Generating and assessing evidence for nursing practice*, 11th edition. Philadelphia, PA: Wolters Kluwer.
17. Sedgh, G. and Hussain, R. (2020) 'Reasons for contraceptive nonuse among women with unmet need'. *Studies in Family Planning*, 51(2), pp. 107-125.
18. Silumbwe, A., Nkole, T., Munakampe, M.N., Milford, C., Cordero, J.P., Kriel, Y., Zulu, J.M. and Steyn, P.S. (2018). 'Community and health systems barriers and enablers to family planning and contraceptive services provision and use in Kabwe District, Zambia'. *BMC Health Services Research*, 18(1), Article 390.
19. Tashakkori, A. and Teddlie, C. (2010). *SAGE handbook of mixed methods in social and behavioral research*, 2nd edition. Thousand Oaks, CA: Sage Publications.
20. United Nations Department of Economic and Social Affairs (2022). *World Family Planning 2022*. New York: United Nations.
21. Yamane, T. (1967). *Statistics: An Introductory Analysis*, 2nd edition. New York: Harper and Row.
22. Zambia Statistics Agency (ZamStats), Ministry of Health (MOH), and ICF (2024). *Zambia Demographic and Health Survey 2024: Key Indicators Report*. Rockville, MD: ICF.