Challenges in Modern Contraceptive Utilisation Among Adolescents in Selected Parts of Mtendere Compound, Lusaka District, Zambia.

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ABSTRACT

Zambia's relatively early age at sexual debut and a persistently high adolescent pregnancy rate of approximately 29%, modern contraceptive use among adolescent girls aged 15 to 19 remains low at 12.0% nationally, with utilisation being lower among urban adolescents (9.8%) than rural adolescents (13.7%).

A qualitative case study design was used, with Mtendere compound, Lusaka District, as the bounded case. A purposive sample of 30 adolescents aged 15 to 19 participated, comprising 14 individual semi-structured interviews (7 female, 7 male) and two gender-specific focus group discussions of eight (8) participants each.

The study identified key challenges that adolescents face in contraceptive use within Mtendere compound, including compromised privacy, informal institutional gatekeeping, and discontinuation driven by compounding social pressures. Challenges rarely operated in isolation; compound density converted private health matters into family crises, informal gatekeeping by health workers exceeded actual policy, and the compounding of these pressures led some adolescents to discontinue methods already begun, choosing the risk of pregnancy over the social risk of seeking further support.

The study concluded that challenges interact simultaneously across individual, interpersonal, institutional, and community levels, rather than by any single barrier. Therefore, the study recommends redesigning facility layouts to reduce visibility, enforcing consistent age-of-consent policy, reconsidering peer-based staffing for youth-friendly services, and redesigning promotional materials to include unmarried adolescents.

Keywords: Adolescent contraceptive use, access, values and perceptions, challenges, social-ecological model, Mtendere compound, Zambia.

BACKGROUND

Sexual and reproductive health among adolescents has held a place on the global health agenda for decades, formalised most directly in Sustainable Development Goal Target 3.7, which calls for universal access to family planning information and services. Progress toward that target has been real but uneven, and adolescents have consistently been the group left furthest behind it. Globally, an estimated 57% of sexually active adolescent girls in developing countries who wish to delay or limit childbearing are using a modern contraceptive method, which means the remaining 43%, a substantial minority, want to avoid pregnancy but are not protected against it (Tumlinson et al., as cited in regional unmet need literature, 2019 estimate). That gap, between wanting to delay pregnancy and actually being able to, is where much of adolescent sexual and reproductive health policy has tried, with mixed success, to intervene.

Zambia illustrates both the urgency and the difficulty of that intervention. Sexual activity among Zambian adolescents begins relatively early: a 2022 cross-sectional study spanning twenty districts with the highest HIV incidence in the country found a mean age at first sex of 16.6 years among adolescent girls and young women, slightly earlier among those out of school (16.8 years) than those still in school (16.2 years) (Musonda et al., 2024). That early start has not been matched by early or adequate contraceptive protection. National survey data show that only 12.0% of adolescent girls aged 15 to 19 in Zambia were currently using a modern contraceptive

method, with use somewhat higher among rural adolescents (13.7%) than urban ones (9.8%), a pattern the same study attributes partly to the fact that urban contraceptive use is concentrated among adolescents who are older, married, or already have a child, rather than reflecting broader access among younger, unmarried urban girls (Sserwanja et al., 2022). The consequence of that gap is visible in Zambia's adolescent pregnancy rate, which the 2018 Zambia Demographic and Health Survey placed at approximately 29%, nearly three in ten adolescent girls having already begun childbearing, a figure that has remained stubbornly close to that level across successive survey rounds rather than declining meaningfully.

Lusaka's informal urban settlements, Mtendere compound among them, sit at a particular intersection of this national picture. These are dense, low-income communities where modern contraceptive methods, condoms, oral pills, injectables such as Depo-Provera, and longer-acting options like the Jadelle implant, are generally available at the public health facilities serving the area, at least in principle. Availability has not translated into consistent use. Qualitative research conducted across four Zambian districts found that adolescent girls' decisions about contraception are shaped only partly by whether a method is physically accessible; far more often, those decisions are negotiated against the views of parents, peers, partners, and religious communities, all of whom hold strong and frequently conflicting opinions about whether a girl who is not yet married should be using contraception at all (Chola, Hlongwana and Ginindza, 2023).

A companion study by the same research team, conducted through focus group discussions and interviews with adolescent girls in similar Zambian settings, documented the lived texture of that negotiation directly: girls who sought contraceptive services described navigating fear of being recognised by someone from their own community, uncertainty about whether a provider would judge them, and persistent worry about side effects ranging from changes to their menstrual cycle to rumours that modern methods cause permanent infertility (Chola, Hlongwana and Ginindza, 2023).

However, this body of evidence did not examine this negotiation specifically within Mtendere compound, or hold the three dimensions, access, value, and challenge, together within a single study designed to let adolescents describe them in their own words. National survey data of the kind reviewed above provides an indication that a gap exists between need and use. It cannot explain, in any detail, what an adolescent in Mtendere actually does when she decides she wants contraception, what she believes about what that decision means for her, or what specifically stands between that decision and its completion.

A broader Zambian study of inequality in contraceptive use and unmet need across the country has shown that these patterns are shaped by overlapping individual, household, partner, and community-level factors operating much like a social-ecological system (Kazibwe et al., 2024), reinforcing the case that no single level of explanation, individual belief, family pressure, or service delivery alone, is likely to capture what is happening on the ground in a setting as specific as Mtendere. This study takes up that gap directly.

The challenges adolescents face once they attempt to use a contraceptive method, separate from the prior questions of whether they can access one or what they believe about it, have themselves been the subject of substantial global synthesis. A systematic review of contraceptive values and preferences among adolescents and young adults, searching ten databases for studies published between 2005 and 2020 and ultimately drawing on fifty-five studies across sixteen countries, identified the influence of social context and the influence of myths and misconceptions, particularly around safety and side effects, as two of the five most commonly discussed themes in the global literature on this population (Contraception journal systematic review, 2021).

A scoping review mapping decision-making on contraceptive use among adolescents across the region, synthesising seven studies through thematic analysis explicitly grounded in the social-ecological model, found that challenges operated simultaneously at the individual level, fear of side effects and fear of infertility, the parental level, disappointment and disapproval, the peer level, social stigma, the partner level, association with promiscuity and multiple sexual partners, the societal and community level, broader disapproval and stigma, and the institutional and environmental level, lack of privacy and confidentiality in service settings (Chola, Hlongwana and Ginindza, 2023).

A qualitative study of barriers to contraceptive use among urban adolescents and youth in Conakry, Guinea, drawing on in-depth interviews with adolescents, youth, and key informants including health workers, parents, and decision-makers across five communes, arrived at a strikingly similar four-category structure independently: individual barriers including fear of side effects, cost, and rumour-driven misinformation; interpersonal and family barriers including a partner's own perception and the taboo status of sexuality before marriage; sociocultural barriers including religious prohibition; and health system barriers including stock breakdowns at public facilities, provider attitudes, inconvenient visiting hours, and inadequate provider training (Dioubaté et al., 2021).

Justification of the Study

Chola, Hlongwana and Ginindza (2023) found that fear of provider judgement and fear of community recognition were recurring themes in how Zambian adolescent girls described their own contraceptive-seeking experiences elsewhere in the country. Whether those same dynamics, or different ones specific to Mtendere's particular social geography, are at play here is something facility staff currently have no local evidence to draw on. National literature already confirms that myths and fears about side effects, infertility, and moral judgement shape contraceptive decisions among Zambian adolescents in general terms (Chola, Hlongwana and Ginindza, 2023). What is far less clear is which of these specific fears carry weight in Mtendere, and how adolescents there talk about them in their own words. Kazibwe et al. (2024) demonstrated that inequality in contraceptive use in Zambia operates through layered, overlapping factors at the individual, household, and community level. Examining how those layers actually interact within one specific, lived environment is precisely the kind of contribution a focused qualitative case study is positioned to make, and that the existing literature has not yet provided for Mtendere.

Purpose of the Study

The purpose of this study was to explore the challenges faced by adolescents in selected areas of Mtendere compound, drawing directly on adolescents' own perspectives gathered through individual interviews and gender-specific focus group discussions. This approach aimed to capture lived experiences in order to highlight context-specific barriers and inform responsive interventions.

Theoretical Framework

This study is guided by the Social-Ecological Model, a framework that understands individual behaviour as the product of influences operating at several interacting levels rather than as the outcome of personal decision-making alone. Originally developed within public health and health promotion to explain how behaviour is shaped jointly by the individual and the environment surrounding them, the model has since been applied widely to adolescent sexual and reproductive health specifically, including, directly and recently, to the question this study investigates. A qualitative study of barriers to contraceptive use among urban adolescents in Conakry, Guinea, arrived at a four-category structure, individual, interpersonal and family, sociocultural, and health care system, that maps closely onto the social-ecological model's levels even though that study did not set out to apply the framework explicitly (Dioubaté et al., 2021). Two independent research teams, working in two different countries, using different methods, converged on essentially the same layered account of how adolescent contraceptive behaviour is shaped. That convergence is itself strong evidence that a single-level model, one that looks only inside the adolescent's own head, would not adequately capture what is actually happening.

METHODOLOGY

Research Design

This study used a qualitative case study design, with Mtendere compound serving as the bounded case within which the phenomenon of adolescent modern contraceptive utilisation was examined in depth (Yin, 2018). A case study design was appropriate because the study sought an intensive, contextually grounded understanding of a single setting, rather than a comparison across multiple settings or a claim of generalisability to adolescents elsewhere in Zambia.

Study Population

The study population comprised adolescents aged 15 to 19 years residing in selected parts of Mtendere compound at the time of data collection. This population was selected because adolescents within this age band were the individuals most directly engaged in, or approaching, the contraceptive decisions

Sample and Sampling Procedure

A purposive sample of 30 adolescents was selected for this study, a sample size consistent with established guidance for qualitative case study designs, which typically recommends a range sufficient to reach thematic saturation within a bounded setting without extending data collection beyond the point at which new information ceases to emerge (Creswell and Poth, 2018).

Data Gathering Techniques

Two primary data collection tools were used: an individual interview guide and a focus group discussion guide, both reconstructed for this study around its three specific objectives rather than around the broader thematic structure used in earlier related work. All data collection tools were developed in English and translated into Nyanja and Bemba, the two languages most commonly spoken within Mtendere compound, to ensure that participants could express themselves in the language in which they were most comfortable. Each participant was given the choice of language at the outset of their interview or focus group discussion, and trained research assistants fluent in both Nyanja and Bemba facilitated sessions conducted in either language.

Data Analysis

Audio recordings of interviews and focus group discussions, made with participants' consent, were transcribed verbatim and translated into English where sessions had been conducted in Nyanja or Bemba. Transcripts were analysed using thematic analysis, following Braun and Clarke's six-phase approach: familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final analytic account (Braun and Clarke, 2006).

Coding and thematic development were conducted using NVivo 13 qualitative data analysis software, which supported systematic organisation of codes across the full dataset and facilitated comparison of themes across individual interviews and focus group discussions, and across male and female participants.

Data Quality and Integrity

Validity and reliability of the research work were based on the trustworthiness criteria established by Lincoln and Guba (1985), and later discussed by Creswell (2013), namely credibility, transferability, dependability, and confirmability.

Ethical Consideration

Prior to conducting the study and engaging adolescents in interviews and focus group discussions, all ethical protocols were observed. The research proposal received clearance from the University of Lusaka Ethics Committee and the National Health Research Authority (NHRA). In addition, approval was sought from community leaders, and informed consent was obtained from individual participants to ensure voluntary participation, confidentiality, and respect for participants' rights. All participants were informed of the purpose of the study, what participation would involve, and their right to withdraw at any time without consequence.

Limitations

This study was limited to a single urban compound, meaning findings cannot be generalised to adolescents in other settings. Data relied on self-reported accounts, which may be subject to recall bias or social desirability bias. In addition, the study did not include health worker perspectives, which could have provided valuable

triangulation of findings on informal gatekeeping and service delivery. Future research should incorporate health provider interviews and comparative studies across multiple compounds to strengthen the evidence base.

FINDINGS OF THE STUDY

Challenges in Modern Contraceptive Utilisation Among Adolescents

The challenges adolescents in Mtendere described were rarely isolated obstacles that could be addressed one at a time. Across both individual interviews and focus group discussions, participants described how an individual fear, a family pressure, and a structural barrier at the health facility tended to operate together, each one compounding the others until the cumulative effect was simply that the adolescent stopped trying to use a method at all. Through individual interviews and two focus group discussions of 30 adolescents, the study established three sub-themes emerged from the data. The first concerned how the physical density of the compound itself converted private health matters into public family crises. The second addressed informal institutional gatekeeping by health workers acting outside any actual policy requirement. The third examined how the compounding of these pressures led directly to discontinuation of contraceptive use.

Compound Density and Loss of Privacy

For several participants, the most fundamental challenge in using a modern contraceptive method had nothing to do with obtaining it and everything to do with managing its physical effects once it had been obtained. The dense, shared living arrangements that characterised Mtendere compound meant that bodily changes a method produced, however minor, rarely remained private for long.

Below are the verbal responses illustrating how adolescents navigate contraceptive use in the face of compounding social and institutional pressures:

“The pills caused me to have random, heavy bleeding for three weeks. In our yard we share one pit latrine and one bathing room. If you want to wash your underwear, you have to do it outside near the communal tap where everyone is fetching water. You cannot hide anything in this compound. My mother noticed the bleeding pattern and started demanding answers.” (IDI 11, Female, 17 years)

What this account illustrates is that the structural challenge of compound density did not simply make access difficult, it made the consequences of access, the physical experience of using a method, equally difficult to manage discreetly. A participant who had successfully obtained a method through an informal pathway, bypassing the exposure risk of the clinic entirely, could still find herself exposed at home through a side effect she had no way of concealing in a household with no private washing or sanitation facilities.

“She came into the room when I went to school and searched everywhere until she found the packet. She screamed at me that I am a prostitute, that I have aborted a baby.” (IDI 11, Female, 17 years)

The severity of this reaction, accusations of prostitution and abortion arising from what was, medically, an unremarkable hormonal side effect, illustrates how directly the values fed into the challenges documented here. A side effect was not simply a physical inconvenience to be managed. It was, in this dense social environment, evidence that could be discovered and interpreted through the same moral lens that already equated contraceptive use with sexual deviance.

Informal Institutional Gatekeeping

A second significant challenge concerned the behaviour of health workers themselves, specifically the imposition of requirements that exceeded what any actual national policy required, effectively manufacturing an additional barrier that existed only within that individual provider's own practice.

"I built up the courage to visit the public clinic to request an IUD. But the nurse looked at my card, realised I was unmarried and nineteen, and flatly refused to assist me unless I brought my mother to sign the registration book. There is no national policy in Zambia that requires this for a nineteen-year-old."

This account is significant because the participant in question was, by national policy, fully entitled to access the service she sought without any parental involvement at all. The barrier she encountered was not a gap in policy or an absence of available stock. It was a barrier invented, in the moment, by an individual provider applying their own personal standard. This participant described the encounter escalating further, into public humiliation:

"She openly yelled at me in front of the full waiting room, saying that girls like me bring curses onto this compound. This institutional humiliation is a massive barrier. You are trying to act responsibly, but the health workers humiliate you publicly, ensuring you will never risk stepping foot inside that facility again." (IDI 13, Female, 19 years)

The lasting consequence described here, an explicit decision never to return to the facility, illustrates that informal gatekeeping of this kind did not simply delay or complicate access on a single occasion. It permanently closed off a formal access pathway for the individual affected, pushing her toward the informal, and less clinically safe alternatives or toward no method at all.

Compounding Pressures and Discontinuation

The third and most analytically significant sub-theme concerned what happened when the pressures documented above, individual fear, family surveillance, and institutional gatekeeping, did not occur in isolation but compounded one another within a single adolescent's experience, and what the cumulative effect of that compounding actually was. A participant in FGD 01, aged 18, offered the clearest articulation of this dynamic, describing how an ordinary, manageable health concern became an unmanageable social risk specifically because of the layered exposure built into every step of the access pathway:

"A simple fear of side effects, like missing your period, becomes an absolute crisis here. If I miss my period because of the injection, I cannot easily go back to the clinic to get checked, because going back means navigating that same public corridor and facing the same judgemental staff. With exposure at every level of the access path, a simple health worry becomes a major social risk." (FGD 01, Female Participant)

This participant then described the behavioural outcome of that compounding directly:

"So, what do girls do? They simply stop using the method entirely. They throw the remaining pills away and choose to risk pregnancy rather than face going back." (FGD 01, Participant)

This finding offers the clearest in the dataset, of the social-ecological framework at work. No single level explains the outcome. At the individual-level, fear of a side effect is genuine, but such concerns would typically prompt a return visit for reassurance. What transforms that ordinary health-seeking response into discontinuation is the interpersonal risk of being seen by a relative, the institutional risk of facing a judgemental provider, and the community-level certainty that either encounter would become known beyond the clinic walls. It is the interaction of all four levels simultaneously, not any single one of them, that produces the outcome this study set out to understand: an adolescent who successfully initiated a modern contraceptive method, but discontinued not because the method failed, but because the social cost of continuing outweighed the risk the method was designed to prevent.

DISCUSSION OF THE FINDINGS

Challenges in Modern Contraceptive Utilisation Among Adolescents

The finding that compound density itself, the close physical proximity of households, shared sanitation, and communal washing areas, functioned as an active barrier to managing contraceptive side effects discreetly

extends the existing literature into territory that global and regional sources have previously identified only in passing.

Barriers of Privacy and Confidentiality

The Social-Ecological scoping review by Chola, Hlongwana and Ginindza (2023) listed "lack of privacy and confidentiality" as an institutional and environmental-level barrier, but framed this primarily in relation to clinical settings, the privacy of the consultation room rather than the privacy of the home. Participant 11's heavy bleeding became a household crisis specifically because washing facilities were shared among several families and located in an open communal yard, relocates this barrier from the clinic to the home itself. This is a meaningful extension. It suggests that even an adolescent who successfully avoids the exposure risks by obtaining a method through an informal peer network rather than a clinic visit, remains exposed to discovery through an entirely separate pathway: the physical evidence her own body produces once she begins using that method.

Disclosed vs. Discovered: Involuntary Pathways to Stigma

This finding also sharpens something the Conakry study by Dioubaté et al. (2021) identified at a more general level. That study's four-category structure, individual, interpersonal, sociocultural, and health system barriers, treated these as related but analytically distinct categories. The finding discussed here demonstrates a specific mechanism by which an individual-level concern, a physiological side effect, becomes, almost automatically, an interpersonal crisis, without any deliberate disclosure decision on the adolescent's part at all. IDI Participant 11 did not choose to tell her mother about her bleeding. Her mother discovered it through the unavoidable visibility of washing patterns in a shared communal space. This distinction between disclosed and discovered values matters for how this finding should be interpreted. Much of the literature on adolescent contraceptive stigma assumes a moment of choice, whether to tell a parent, a partner, a friend. The finding here suggests that in a setting as dense as Mtendere, that choice may not always exist, since the body itself can disclose what the adolescent never intended to reveal.

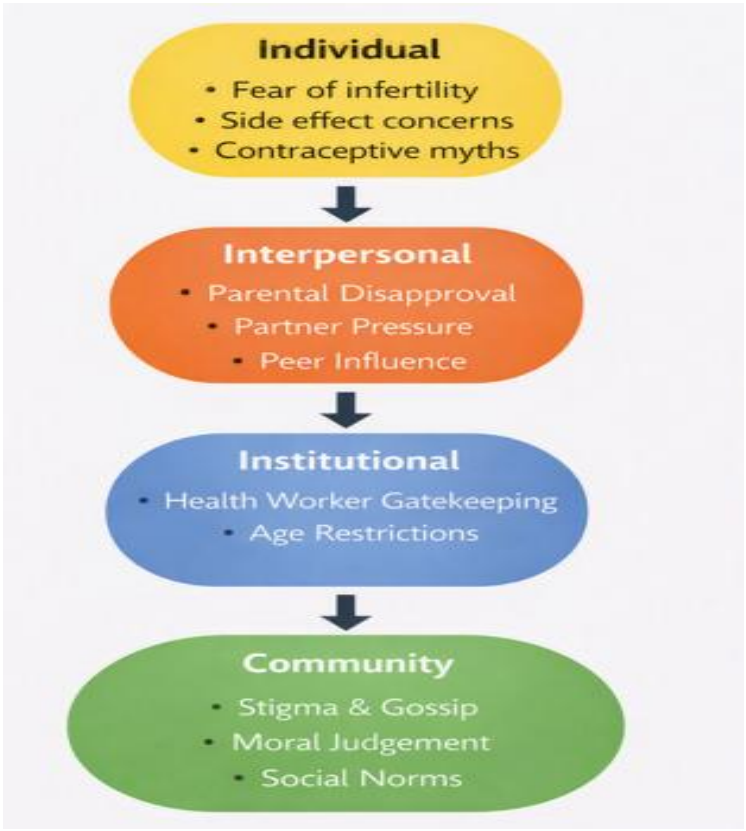
Informal Institutional Gatekeeping

The informal institutional gatekeeping, health workers imposing requirements, such as mandatory parental consent for a nineteen-year-old, that no actual Zambian policy requires, confirmed a pattern already well established in the regional literature. The Guinea study found health care system barriers including "provider attitudes" and "quality of training received by health care providers" operating alongside structural barriers such as stock shortages. The finding here adds specificity regarding the mechanism through which provider attitude translates into a concrete barrier. It is not simply that a provider was unfriendly or unwelcoming, the more general framing the regional literature typically uses. It is that a specific, individual provider invented a procedural requirement on the spot, one with no basis in national guidance, and that this invented requirement was sufficient to deny a legally entitled adult-aged adolescent the service she sought. This finding reveals a precise policy implication that broader accounts of ‘negative provider attitudes’ often obscure, the problem documented here is not primarily one of attitude or training in the abstract, but of the absence of any mechanism holding individual providers accountable to the actual policy they are meant to be implementing. Within the Social-Ecological Model, this is the point at which the interpersonal and institutional levels blur into one another: a single provider's personal conviction, unchecked by any institutional constraint, was able to function with the full blocking force of official policy.

The compounding pressures and discontinuation findings engage most directly with the theoretical framework adopted in this study and the one that most clearly demonstrates why a single-level model would have been inadequate to this study's purpose.

The findings of this study demonstrate that adolescent contraceptive utilisation in Mtendere compound cannot be explained by individual choice alone. Instead, it is the product of layered influences that interact simultaneously across the levels of the Social-Ecological Model. At the **individual level**, fears of side effects and myths about infertility shaped decisions even before adolescents attempted to access services. At the

interpersonal level, parental disapproval and peer surveillance reinforced these fears, often transforming private health concerns into family crises. At the **institutional level**, clinic architecture and informal gatekeeping by health workers created invented barriers beyond policy, deterring adolescents from seeking services even when methods were available. At the **community level**, stigma and gossip amplified the risks of being seen to use contraception, equating contraceptive seeking with promiscuity. These levels did not operate in isolation; they compounded each other, producing outcomes that no single level alone could explain.



The compounding pressures documented in this study illustrate how structural and social density magnify adolescent vulnerability. For example, the physical exposure of clinic layouts interacted directly with community stigma, meaning that the act of walking into a facility was itself read as evidence of moral failing. Similarly, myths about infertility were reinforced by male partners under the guise of care, showing how interpersonal relationships transmitted inaccurate beliefs that carried institutional consequences when adolescents avoided formal services. This convergence across levels underscores the importance of multi-dimensional interventions. Addressing only one barrier such as stock availability or provider training will not meaningfully improve utilisation in a setting where individual fears, family surveillance, institutional design, and community stigma overlap so tightly.

This finding connects directly back to the global pattern documented by Munakampe, Zulu and Michelo (2018), who found that adolescents facing blocked access to safe contraceptive or abortion options sometimes resorted to dangerous alternative methods entirely. The discontinuation pattern documented in this study's findings describes a related but distinct risk pathway: not the adoption of a dangerous alternative, but the abandonment of an already-adopted safe method, in favour of unprotected exposure to the very risk, unintended pregnancy, the method was meant to prevent. Both findings, considered together, suggest that the consequence of compounding access, value, and institutional barriers is rarely that adolescents simply do without contraception passively. It is that they actively disengage from safe methods already in use, or turn to unsafe alternatives, precisely at the moments those methods require ordinary, low-stakes maintenance, a follow-up visit, a question answered, that the compounding pressures documented throughout this chapter make to feel anything but low-stakes.

An important distinction also emerged between **older and younger adolescents**. Older adolescents, particularly those aged 17 to 19, faced immediate contraceptive decisions shaped by active sexual relationships and visible

risks of pregnancy. Their accounts reflected urgent negotiations between privacy, stigma, and access. Younger adolescents, closer to 15 or 16, often described contraceptive use as prospective rather than immediate, shaped more by myths, parental warnings, and peer narratives than by direct service encounters. This difference suggests that interventions must be age-stratified: younger adolescents require early, accurate information to counter myths before sexual debut, while older adolescents need confidential, accessible services that protect privacy in socially dense environments.

By explicitly situating these findings within the SEM, this study contributes to adolescent SRHR literature by showing how compound density transforms private contraceptive decisions into public exposure, and how informal gatekeeping creates barriers beyond policy. The evidence highlights that adolescent contraceptive utilisation in Mtendere is not simply a matter of availability, but of layered pressures that interact to produce discontinuation and avoidance. Thisinsight strengthens the case for integrated interventions that simultaneously address individual beliefs, family dynamics, institutional design, and community norms.

CONCLUSION

This study has shown that modern contraceptive utilisation among adolescents in Mtendere compound is shaped by the simultaneous interaction of access barriers, values and perceptions, and compounding challenges across individual, interpersonal, institutional, and community levels. By explicitly situating these findings within the Social-Ecological Model, the study demonstrates that adolescent contraceptive behaviour cannot be understood through individual choice alone. Instead, it emerges from layered influences that overlap and reinforce one another, producing outcomes that no single level of analysis can explain.

The contribution of this study lies in its ability to document these dynamics within a single, densely populated urban compound, offering context-specific evidence that national surveys and broader multi-district studies cannot capture. It advances the literature by showing how compound density transforms private contraceptive decisions into public exposure, and how informal gatekeeping creates barriers beyond policy. For policymakers, the findings highlight the gap between policy intention and adolescent reality, underscoring the need for interventions that address privacy, stigma, and institutional design alongside availability.

An important distinction also emerged between younger and older adolescents. Older adolescents, particularly those aged 17 to 19, faced immediate contraceptive decisions shaped by active sexual relationships and visible risks of pregnancy. Their accounts reflected urgent negotiations between privacy, stigma, and access. Younger adolescents, closer to 15 or 16, often described contraceptive use as prospective rather than immediate, shaped more by myths, parental warnings, and peer narratives than by direct service encounters. This difference suggests that interventions must be age-stratified: younger adolescents require early, accurate information to counter myths before sexual debut, while older adolescents need confidential, accessible services that protect privacy in socially dense environments.

By integrating these insights, the study contributes both to academic literature and to policy practice. It reinforces the importance of multi-level interventions that simultaneously address individual beliefs, family dynamics, institutional design, and community norms. In doing so, it provides a clearer roadmap for improving adolescent sexual and reproductive health in Zambia’s urban compounds, ensuring that modern contraceptives are not only available but genuinelyaccessible and acceptable to the young people who need them most.

Community-Based Distribution Models

The findings of this study highlight that clinic visits in Mtendere compound often carry significant social risks, with adolescents deterred not by the absence of contraceptive methods but by the visibility of service points and the likelihood of being recognised or judged. In such a socially dense environment, community-based distribution models provide an important alternative pathway for adolescents to access modern contraceptives safely and discreetly. By shifting distribution away from highly visible clinic corridors and into more confidential channels, these models can reduce exposure while protecting privacy.

Community-based approaches could include door-to-door outreach conducted by trained agents who are not embedded within the same compound, discreet distribution through youth organisations, or integration of contraceptive provision into broader community health activities where the purpose of the visit is less easily identifiable. Importantly, these models must be designed with safeguards to ensure confidentiality and avoid reinforcing stigma. For example, peer educators drawn from outside the immediate compound may be better positioned to provide confidential services than those who live within the same social networks.

Such innovations would not replace facility-based services but complement them, offering adolescents multiple pathways to obtain contraception without fear of public exposure. By recognising that compound density transforms private health decisions into public matters, community-based distribution models directly address one of the most significant barriers identified in this study. Their adoption could therefore play a critical role in bridging the gap between policy intention and adolescent reality, ensuring that modern contraceptives are not only available but genuinely accessible in the environments where young people live.

RECOMMENDATIONS

Based on these findings, several recommendations are proposed.

First, health facility management serving Mtendere compound should prioritise redesigning clinic layouts to reduce visibility of family planning services. Privacy-enhancing architectural changes, such as separate entry points or discreet service areas, would mitigate the exposure that currently deters adolescents from seeking care.

Second, the Lusaka District Health Office should enforce consistent application of age-of-consent policies, ensuring that adolescents are not subjected to informal gatekeeping by health workers. Regular audits and supervisory mechanisms could help monitor adherence.

Third, youth-friendly service models should be reconsidered, particularly the reliance on peer educators drawn from the same community. While intended to build trust, this approach inadvertently increases the risk of disclosure in a socially dense compound. Alternative staffing models, such as non-resident peer educators or trained young professionals, may better balance relatability with confidentiality.

Fourth, health communication and behaviour change programming should redesign promotional materials to explicitly include unmarried adolescents, challenging the moral coding that equates contraceptive use with promiscuity. Campaigns should directly address myths about infertility and side effects, using language and imagery grounded in the lived experiences of Mtendere adolescents. Fifth, the Ministry of Health should explore community-based distribution models that reduce reliance on clinic visits. Given that compound density makes facility-based access socially risky, discreet door-to-door outreach or distribution through trusted non-resident agents could provide safer alternatives.

Finally, future research should expand beyond adolescent accounts to include provider perspectives, enabling triangulation of findings on informal gatekeeping and service delivery. Comparative studies across multiple compounds would also help determine whether the dynamics observed in Mtendere are unique or representative of similar urban settlements. By implementing these recommendations, stakeholders can move closer to bridging the gap between policy intention and adolescent reality, ensuring that modern contraceptive services are not only available but genuinely accessible, acceptable, and usable by the young people who need them most.

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