

DETERMINANTS OF CONTRACEPTIVE USE AMONG YOUNG WOMEN IN  
LESOTHO

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## DECLARATION

Submitted in fulfilment / partial fulfilment of the requirements for the degree of Masters in Population Studies, in the Graduate Programme in Population Studies, University of KwaZulu-Natal, Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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## ACRONYM

AIDS	Acquired Immuno-deficiency Syndrome
HIV	Human Immunodeficiency Virus
LDS	Lesotho Demographic Survey
LDHS	Lesotho Demographic and Health Survey
LRHS	Lesotho Reproductive and Health Survey
MOHSW	Ministry of Health and Social Welfare
PRB	Population Reference Bureau
STI	Sexually Transmitted Infections

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## **DEDICATION**

I dedicate this dissertation to my late father, Mr. Sehloho Mabele and my late grandmother, nkhono 'Manthona Mosehle whose efforts gave me a good background.

## **ABSTRACT**

The study is titled 'Determinants of contraceptive use among young women in Lesotho'.

Caldwell and Caldwell (2002:80) assert, "The most serious problem with existing sub-Saharan family planning programs is their neglect at adolescents' needs". The main objective of the study is to investigate factors influencing the use of modern contraceptives among young women (15-24 years old) in Lesotho and to contribute towards improvements in health care services for adolescents. The study will examine the levels of contraceptive use among young people in Lesotho, and explore social and demographic factors that promote contraceptive use. The study is based on the data from 2004 Lesotho Demographic and Health Survey which is a representative sample.

The study showed that young people have high knowledge of modern methods of contraceptive (knowledge ranked up to 91 percent) however use of methods is lower (ranked up to 44 percent). Traditional methods were the least known except for withdrawal which had a plausible percentage (64.7 percent). Most of sexually active young people have ever used contraceptives and injectables were the leading method while condoms were the most generally known. The study also showed that contraceptive use increases with age, level of education, wealth and discussion of family planning with partner. Results of the logistic regression analysis, however, showed unexpected results where adolescents' from the rural areas had a higher likelihood of using contraceptives than those from urban areas. Married young women had a high level of contraceptive use than those never married. Socio-cultural context hinders the establishment of reproductive programs on adolescents as their sexuality is attached to marriage and childbearing. It was recommended that intensive programs informing young people about their reproductive decision-making is needed.

# **CHAPTER 1**

## **BACKGROUND OF THE STUDY**

### **1.1 Introduction**

Contraception is the practice of inhibiting conception with the aim of delaying, spacing births or limiting childbearing (Rimal, 2003; Mauldin and Segal, 1988; Mturi, 1996). After independence in 1966, Lesotho was faced with high population growth rate in the 1980s and 1990s due to a high fertility rate, which has put a strain on the country's economic development (Mturi and Hlabana, 1999). This led the government of Lesotho into establishing a policy that was aimed at achieving a replacement level of fertility by 2011. According to Tuoane, Madise and Diamond (2004), the government formed and approved the Lesotho Planned Parenthood Association (LPPA) later in 1968 that would provide family planning services to Basotho focusing mainly on women after debating on negative attitudes that would come from the pronatalists. However, the government became fully involved with family planning activities in the 1970s. Coupled with high fertility was high teenage pregnancy and sexually transmitted infections (STIs) including HIV/AIDS (LRHS, 2003).

By the year 2004, adults who were HIV positive made up 24 percent of the population (LDHS, 2004). The LDHS report further indicates that women constitute a high percentage of people infected with HIV (26 percent as opposed to 19 percent of men) and this is because of their inability to negotiate safe sex due to power differentials. Woman's status plays an important role in influencing contraceptive use. In Lesotho mean age at first sexual intercourse are 18.1 years for males and 17.4 years for females. Boys usually start their first sexual intercourse at 15 (LRHS, 2003). Moreover, the report indicates that though there is high teenage fertility in the rural areas than at national level, overall fertility is declining in Lesotho meaning teenage fertility has minimal impact.

Since 1990s, many government health facilities in Lesotho are offering family planning services (Mturi and Hlabana, 1999). Knowledge of contraceptives is increasing over time whereby most people have heard or used one method of family planning. Knowledge of contraceptives among women and men seem to be universal in Lesotho (LRHS, 2003). The LDHS, 2004 indicate that 99.7 percent of young sexually active people know about a method

of contraception. The methods of contraception available in Lesotho include are vasectomy, female sterilization, male condoms, pills, injectables, IUD and spermicides. Female condoms and implants are available, but not widely used at the population level. Tuoane, Madise and Diamond (2004) assert that the pill and injectables remains the most used and recommended methods of contraception. More recently the prevalence of the male condom has increased due to its dual protection against pregnancy and STIs including HIV/AIDS and it does not need prescription. The spread of HIV/AIDS also influences contraceptive use among young women and men because the methods will help to prevent the infection (LRHS, 2003).

Traditionally, pregnancy and childbearing is expected to resume at marriage (Nare, Katz and Tolley, 1997). However, the reality is that young peoples' sexuality does not begin at marriage. As a result, this led to neglecting young people's unmet needs for contraceptives. Tuoane, Madise and Diamond (2004) conducted a study on the provision of family planning and excluded teenagers and young people who were already sexually active. Makatjane (2002) focused on the prevalence of premarital sexual activity, childbearing and its implications where the results indicate that children suffer the consequence of humiliation during traditional gatherings. Sub-Saharan family planning programs have problems of neglecting unmarried adolescents' contraceptive needs (Caldwell and Caldwell, 2002; Thompson and Spanier, 1978). Thus, contraceptive use in most of these African countries remains below the level needed to alleviate threats to sexual and reproductive health. This study will shed light on the benefit from services that offer information and support to these young people. Young people are at the critical stage where they are faced with many challenges that affect their transition to adulthood and this is the time of heightened risks for them; thus there is need for interventions at an early stage to overcome any obstacles, and secure a better future. In addition, this study hopes to assist program and policy makers to better understand factors that influence contraceptive use among young people in order to help them lead healthy sexual and reproductive lives especially in the era of HIV/AIDS.

## **1.2 Background features of Lesotho**

### **1.2.1 Geography of Lesotho**

Lesotho is an independent kingdom in Southern Africa bordered completely by the Republic of South Africa. The country is divided into ten administrative districts which differ in terms of size, topology, climate and stage of development. It has been established that rural

populations are the most disadvantaged. Lesotho is distinguished by high altitude terrain hence it is sometimes referred to as the 'Mountain Kingdom' or 'Kingdom in the Sky'. It is also often called the 'Roof of Africa'. The country has been divided into two residential areas, urban and rural with 80% of the population residing in rural areas (Mturi, 2003). It is further divided into four ecological zones, the Lowlands, Foothills, Mountains and Senqu River Valley. LDHS, 2004 showed that Lesotho was primarily a country of subsistence farming where most people grow food for their own consumption. Traditionally cattle are used in agricultural work like ploughing. In addition, the source of livelihood was also through exportation of labour to the South African mines though recently it has changed as most of these Basotho men have been retrenched resulting in an increased unemployment rate in the country. Basotho people are a group of people identified by one language, Sesotho. They are also classified as homogeneous due to their culture and tradition (LDHS, 2004).

### **1.2.2 Population of Lesotho**

According to the 2006 census preliminary results, the population of Lesotho was estimated at 1.88 million an increase of 0.1% from the results of 1996 census which was 1.86 million and adolescents constitute one quarter (Ministry of Finance and Development Planning, 2007). The country experienced high fertility rates with total fertility rate (TFR) of 5.4 children per woman in the mid 1970s while the annual growth rate was 3.1. However, TFR declined to 4.2 in 2001 and 3.5 in 2004 which is considered to be among the lowest in sub-Saharan Africa (LDHS, 2004). The opposite was observed regarding infant and child mortality rates where trends have increased. Infant mortality rate increased from 75 deaths per 1,000 live births in the period 1995-1999 to 91 deaths per 1,000 live births in 2000-2004. On the other hand, under-five mortality rate increased from 91 to 113 deaths per 1,000 live births within the same period. There has been a decline in life expectancy from 60 years in the mid-1990s to 54 years for women and 45 years for men in 2004 (Ministry of Finance and Development Planning, 2007).

### **1.2.3 Why focus on young people?**

Approximately one quarter of the population of Lesotho comprises of adolescents hence premarital childbearing is common and is increasing at an alarming rate (Mturi, 2003). Furthermore, other studies indicates that adolescent population is high worldwide and varies with regions from 19% in Asia to 23% in Africa especially in the urban areas and is expected

to further increase in the future in Africa. Mturi (2003) and Makatjane (2002) argue that reasons for premarital childbearing maybe due to change in life styles from previous generations. For example, Lesotho is not exceptional from other developing countries like Kenya and Nigeria as practices that used to discourage premarital sex are no more strictly done such as virginity testing and checking brides' chastity immediately after consummation of marriage (Mturi, 2003). In addition, even the food that young people in Lesotho were not allowed to eat because they were considered to increase sexual desire are now encouraged by nutritionists. This is why it is important to investigate contraceptive use of young people separately because as they undergo puberty changes at an earlier age, they react irrationally and bear negative consequences.

WHO (1996) asserts that adolescence has been classified as the time that immediate needs are given first priority by young ones yet the implications are over a lifetime. Furthermore, young people have limited access to resources because of resistance or ignorance from older people who are still more influenced by tradition and culture. While in fact, young people have more knowledge about sexual issues from schools, media as well as technology such as internet. According to UNFPA (2005) adolescents who are in ages ranges 10-14 are classified as early adolescence and 15-19 as late adolescence. The same classification is used in this study. Youth is between ages 15-24 and young people range between ages 10-24. For the purpose of the study, adolescence, youth and young people are used synonymously.

#### **1.2.4 The Impact of HIV/AIDS**

In this era of HIV/AIDS which affects the young generation, condoms can be very helpful in preventing infection hence influence the economic growth. Moreover, condoms are essential to those who are already infected as it will prevent the infection to their partners. Approximately 10 million out of 100 million young people aged 15-24 are living with HIV worldwide where 63% of them live in sub-Saharan African (UNFPA, 2005). HIV/AIDS is the leading cause of death among young people especially young women than men with an estimated 4.3% of women aged 15-24 years compared to 1.5% of men in sub-Saharan Africa (Boonstra, 2007). Hlabana (2007) states that 5.3% is estimated to be people in ages 15-19 living with the virus and increases with age as it triples to 19.5% for those in ages 20-24 in Lesotho. This makes Lesotho the third-highest HIV prevalence rate in the world. Therefore, HIV becomes the determining factor for young people to use condoms in order to prevent

infection. However, Makatjane (2002) argues that social stigma is an inhibiting factor to the increase of contraceptive use. Smith (2004) argues that HIV/AIDS leaves a burden to the kin who has to take care of the orphans left by their parents. Moreover, it affects the economy as it affects those who are in their reproductive and productive which becomes a stark threat for the survival of the country. Thus, in order to curb the spread of HIV, interventions should target young people who are most affected.

### **1.3 Statement of the problem**

Teenage pregnancy has become a public health problem recently in African countries including Lesotho. Makatjane (2002) showed that about 100 million of youths become sexually active each year and this is accompanied by unsafe sex which not only leads to high teenage pregnancy but also exposes young people to sexually transmitted infections (STIs) and HIV/AIDS. Most of these young people especially girls have to drop out of school and stay at home to raise their children which affects their future because education is key to earning a decent livelihood nowadays (Singh and Samara, 1996; Kaufman, de Wet and Stadler, 2001). LRHS (2003) showed that in Lesotho about 23% of adolescents' girls drop out of school because of pregnancy compared to boys of the same age cohort who do not suffer the consequences because they continue with their studies. According to social norms girls are seen as bad influence to their colleagues during their pregnancy (LHDS, 2004). They are considered a burden because of unintended pregnancy. Adolescents' find it difficult to keep their babies and end up abandoning them by leaving them on the streets or in hospitals giving the government an added responsibility of financing the feeding of the babies (Makatjane, 2002).

The study seeks to help policy makers to better understand the needs of young adults especially their reproductive health needs and be more gender-sensitive to consider equity. Furthermore, it will help policy makers understand the constraints in accessing family planning services, and how to improve quality of care to ensure a greater use of health services by young women. Many scholars have indicated that knowledge of contraceptive does not necessarily mean access and use of contraception. If increased contraceptive use by young people will translate into young people becoming healthy, it will in turn make them productive and contribute to Lesotho's socio-economic development (LRHS, 2003). In addition, it will answer the global goal of Education for all because adolescents' will be

retained in school even though it is difficult to control their sexual desires. This study is intended to examine more other factors that can influence access and use of contraceptives. This will help in highlighting factors responsible for the observed patterns of contraceptive use and method choice.

#### **1.4 Objectives of the study**

##### **1.4.1 Aim**

The study is aimed at investigating factors influencing the use of modern contraceptives among young women (15-24 years old) in Lesotho and to contribute towards improvements in health care services for adolescents.

##### **1.4.2 Objectives**

The study will examine the levels of contraceptive use among young people in Lesotho, and explore social and demographic factors that can act to encourage or discourage contraceptive use. Adolescents' self-motivation and the intention to take action to change behavior will influence contraceptive use and choice of methods (Ryan, Franzetta and Manlove, 2007). It will also accentuate the constraints and challenges that young people face to access contraceptives and basic services at health facilities. Recommendations on the actions to be taken by health centers' in order to meet young peoples' needs would be added.

#### **1.5 Organization of the dissertation**

Chapter one gives the background of contraception in Lesotho. The chapter further highlights the aim of introducing family planning in the country. Chapter two brings a brief history of contraceptives use and its impact on the economy of many other developed and developing countries. While chapter three presents the methods used in this study. The results of the findings are presented and discussed in chapter four. Lastly, chapter five gives the conclusions and recommendations of the study.

#### **1.6 Theoretical Framework**

"Fertility behaviour is shaped by demand and supply theory" (Koeing, Foo and Joshi, 2000:1). Easterlin and Crimmins (1985) developed a model of demand and supply which assumes that in order to limit family size one has to take into consideration three factors:



supply of living children, demand for surviving children and fertility regulation costs implying access to fertility control services and supplies. This implies that there has to be a demand in order for goods and services to be supplied which in this case is demand for contraceptives to have fertility at replacement level as aimed by the government of Lesotho. The theory states that demand for birth control, both limiting births and birth spacing have an important role due to high population growth rate that does not seem to correspond with economic growth hardships encountered by many developing countries. In addition, opportunity structure changes that have improved women's status with relation to education and occupation have negative effects on large families because they do not have much time for nurturing and rearing children. Weeks (2005) posit that educated women have been allied to have rational decision-making towards reproduction and they prefer smaller families because they want to invest in quality for their children. Therefore, contraceptive use motivates young sexually active individuals to change their fertility potential because it gives them realistic alternative roles.

The opportunity cost of women participating in the labour force increases the cost of raising many children hence a change to family planning methods. Sexual and reproductive behaviour have an impact on health, demographic and socioeconomic characteristics. Oyedokun (2007) asserts that individuals' belief that certain specific situations can enable them to have control over their health lifestyles gives them courage to initiate them. According to LRHS (2003) young women and men become sexually active at an early age, which puts them at the risk of unwanted pregnancy, as at that stage most of them do not have information about family planning services. The demand for contraceptives can be influenced by different factors, such as age at sexual debut, level of education, smaller age difference between sexual partners, number of concurrent sexual partners and socio-economic status at individual level.

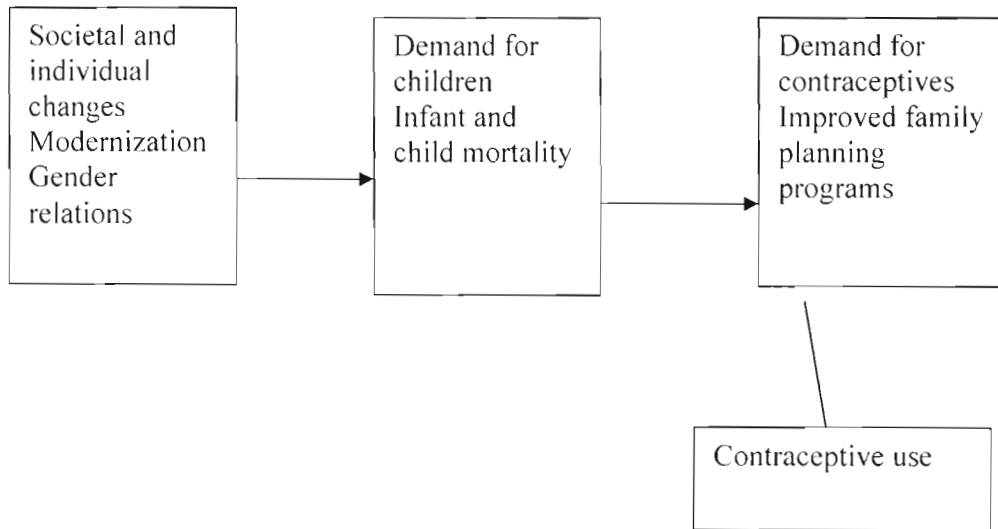
Furthermore, at the societal level factors that can influence the likelihood of using contraceptives could be community fertility preference and attitudes towards family planning, availability of method choice, extent of outreach to different groups and follow-up care to mention a few. Fertility preference can be defined as the desire and timing of births that a woman wants to have. When society develops economically it affects their social status, norms and tastes regarding family formation as they start to value material goods which changes their desire for children (Makinwa-Adebusoye, 2001). Oyedokun (2007) states that

tradition changed in favour of contraceptive methods in many developing countries where there is tolerance of premarital sexual relations due to modernization. Thus, socio-economic changes influence those at the upper class of the community's social status and then innovation through communication networks spreads over other groups (Weeks, 2005; Montgomery, Kiros, Agyeman, Casterline, Aglobitse and Hewett, 2001). Furthermore, Martin (1995) contended that because of these developments, family planning become socially acceptable because people want to maintain their target standard of living thus such a status destiny will be achieved by efficient contraceptives. Then, family planning programmes should start at an early stage of the socio-economic progress (Oyedokun, 2007).

The supply of contraceptives is influenced by resource allocation and regulations, political commitment and organizational factors, such as infrastructure, delivery system, access and cost, quality of skills of staff and services (Tuoane, Madise and Diamond, 2004; Katende, Gupta and Bessinger, 2003). The assumption is that family planning is the best clue to fertility regulation with consistent availability and method choice to clients because unavailability of methods increases the risk of young people to have more unwanted pregnancies (Bhargava, Chowdhury and Singh, 2005). Moreover, increase in the cost of birth controls can also hinder their utilization for young people while considering also provider's disrespect towards them (WHO, 2000). In the case of Lesotho, access can be determined by physical location of the dispensaries' and community based distribution (CBD) that are offering contraceptives as they are the most distributors in the rural communities. Government policies regarding family planning can also influence people to control their fertility behaviour and manage their family sizes.

Demand for contraceptive is due to availability of choice of family planning method. In addition, the choice of method to use is influenced by enabling factors (supply) of services, for example availability of different kinds of modern contraceptives and providers' skills in providing relevant information to the clients. High quality of service is related to the likelihood of increase in contraceptive users, as more clients will be willing to use them. Easterlin and Crimmins (1985) model will be used in this study to investigate whether adolescents' have access to contraceptive use. This is because if young people can obtain contraceptives easily then the alarming rate of premarital teenage pregnancy in Lesotho may be reduced. The authors identified three main determinants of fertility regulation: the demand for children, the supply of children and fertility regulation costs.

*Figure 1: Contraceptive use framework*



## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

Knowledge of contraceptive is universal in most African countries, but is highest in the Northern and Southern part of Africa (Caldwell and Caldwell, 2002). Studies indicate that Swaziland, Botswana and South Africa have achieved fertility declines with modern contraceptives, while in Botswana about sixty percent of new clients enter family planning within a short period of its establishment (Lucas, 1992). Lucas indicates that South Africa has progressed with more than fifty percent utilization of family planning programs. Contraceptive use is considered one of the important proximate determinants of fertility. Westoff and Bankole (2000) assert that results from a number of surveys from different countries indicate a decline in fertility due to an increase in modern contraceptive use in a period of ten years. This implies that the longer interval helps a woman to regain her strength before having another birth while the child is being nurtured.

This high prevalence rate of contraceptive use is a result of, among others, increased age at first marriage and long periods stayed in school where women want to delay their childbearing. In addition, there is a larger adolescent generation reaching puberty and becoming sexually active at an earlier age than previously, due to changes in lifestyles and improved health and nutrition (Pachauri and Santhya, 2002). Moreover, Pachauri and Santhya assert that the highest proportion of these adolescents is in Africa and they expected future rapid growth to remain in this region. There is need for this population to protect themselves from diseases and unplanned/unintended pregnancies. But young people are the largest group with unmet needs of family planning services. Edmeades (2008) argues that young men and women consider the microeconomic theory of fertility regarding the opportunity cost of childbearing whereby when evaluating costs and benefits of children they are likely to adopt contraceptives for better health. Globally, contraceptive use in sexually experienced teenagers is very high especially the hormonal (i.e injections) and condoms with 86 percent overall use; and 88 percent in France, 92 percent in Great Britain and 75 percent in the United States (Salgado and Cheetham, 2003). However, contraceptive use is very low in Lesotho especially among young people as the country has, 39 percent of contraceptive use compared to other African countries, 75 and 54 percent in South Africa and Zimbabwe respectively (LDS, 2001; LDHS, 2004). Nevertheless, these reports indicate an increase of 77 percent in contraceptive

use from 1992 to 2001 among those currently married in Lesotho. Different factors have been identified that influences young people to use contraceptives.

## **2.2 FAMILY PLANNING POLICY IN SUB-SAHARAN AFRICA**

### **2.2.1 Overview of policies on family planning**

The 1974 World Population Conference held at Bucharest was concerned with rapid population growth that seems to be the barrier on development and puts pressure on the economic growth in many Sub-Saharan African countries (Weeks, 2005). Moreover, countries were advised to set goals as well as to meet them. Countries were also encouraged to provide family planning services. After ten years, there was a follow-up conference, the 1984 International Population in Mexico City that emphasized on meeting the ‘unmet needs’ for family planning and education. At the 1994 International Conference on Population and Development (ICPD) Program of Action, many governments made a commitment to provide reproductive and sexual health services (Lush, 2002). More emphasis was put on the provision of family planning services to the lowest marginalized person, thus enable couples to make informed choices (Lush, 2002). Again, the conference concentrated on empowerment of women to take responsibility of their own reproductive health. In other words women should be free to plan their family’s future. Most developing countries including Lesotho, after the aforementioned conferences, decided to implement the recommendations and provide contraceptive services. They realized that high growing population was worsening the standard of living and inhibits development and economic growth of their countries regardless of their efforts to improve health facilities.

### **2.2.2 Policy in Lesotho**

According to Tuoane, Madise and Diamond (2004:4), ‘Lesotho does not have an explicit family planning policy’. However, the goal of the government was to achieve an increase in contraceptive use by 1996 with approximately 31 percent which it failed to meet by 1998. In the absence of direct policy, family planning and child health are included in the national population policy. Due to the constraints placed on economic growth because of rapid population growth as well as the increased number of young people entering reproductive ages, the government formed the Lesotho Planned Parenthood Association (LPPA) in order to achieve its population policy goal of reaching replacement-level of fertility by 2011 (Tuoane, Madise and Diamond, 2004). Moreover, the Ministry of Health and Social Welfare,

(MOHSW) Report (1994) indicates that policy strategy is to swell family planning programs so as to enhance contraceptive prevalence to 75 percent by the year 2011. The report further shows that the aim was to integrate family planning with maternal and child health services, thus from the referral hospital to the lowest clinic. Tuoane, Madise and Diamond (2004) further shows that the population policy was aimed at supplying family planning methods to all health care services as well as adequate information and communication. Nevertheless, the population policy was criticized because it did not include recommendations of the ICPD conference such as adolescents' and young peoples' health concerns, equity and empowerment of women. This may be because the government for a long time did not participate fully in the family planning activities and the policy was introduced prior the conference (Tuoane, Madise and Diamond, 2004)

### **2.2.3 Influence of policy on contraceptive use**

According to UNAIDS (1997) many governments recently have started taking initiatives in the adolescents' reproductive health issues as it has become a public health problem due to high premarital pregnancies and HIV/AIDS. Santhya (2003) argues that most of the African countries policy was to increase access to family planning to the lowest level and this influenced the reproductive behavior of people. Tuoane, Diamond and Madise (2004) showed that the Ministry of Health in Lesotho in collaboration with LPPA and other associations such as Red Cross are the main providers' of family planning methods. The ministry has introduced Parent Education Program (PEP) for parents to understand or be able to feel free to discuss reproductive issues with their children (MOHSW, 1994). Furthermore, they also want to incorporate population and family life (POP/FLE) into the formal education system.

There is a policy draft concerning adolescent sexual and their reproductive health matters as well as the establishment of counseling centres for the youth. Many governments have established activities in order to address these problems like providing information and counseling to enable young people to make rational decisions (UNAIDS, 1997). The report shows that in Cuba the government successfully uses media to provide information for being responsible in sexual conduct and condom use. The ministries of health in Peru and Thailand introduced a policy for provision of free contraceptives for all and these led to an extraordinary change in the family planning market (USAID, 2005). The report further

indicates that there was an increase from 59 to 68 percent of the market share and there was an extended distribution of contraceptives to the rural areas to expand access.

## **2.3 FACTORS INFLUENCING CONTRACEPTIVE USE**

### **2.3.1.1 Educational attainment globally**

‘The 1994 International Conference on Population and Development (ICPD) found that the single most important component a nation can invest in to improve its health is the education of girls and women, thus women empowerment’ (Riyeni, Afifi and Mabry, 2004:144). Oni and McCarthy (1990) showed that in Nigeria contraceptive knowledge and use has increased among those with more than primary education constituting about 98 percent. There has been an increase in contraceptive use influenced by level of education where men with no education constituted 20 percent and 52 percent of those with secondary education (Kenya Demographic and Health Survey, KDHS, 1993). Moreover, the report shows that 78 percent of women using modern methods were not educated while 87 percent had at least a secondary education.

Education is an important factor influencing contraceptive use among sexually active young women and men. Riyeni, Afifi and Mabry (2004) further shows that education gives young women autonomy to make informed choices about their bodies and to resist having unsafe sexual intercourse with their partners, thus being more responsible with their health. An example made was of Egyptian women who have attained high contraceptive use as they participate in the decision-making of family issues including family planning (Riyeni, Afifi and Mabry, 2004). Women with higher levels of education tend to prefer fewer children. Marini (1984) cited in Weeks (1989) stated that higher educational attainment provide better opportunities in life and make available wide range of alternatives to young women. This influences young women to use contraceptives to delay childbearing.

In communities where women’s education is very high, it is associated with low levels of fertility which influences prevailing norms and plays a role in the levels of economic development. According to Debpuur (2002) women who are educated and do not follow traditions have high levels of knowledge and use of modern contraceptives because they want to maintain and enhance their reproductive health. Some clients mostly those educated were willing to pay user fees for family planning services because they argued that their health

comes first and the long term benefits of the methods is greater than that of the fees they have paid (Hennink and Madise, 2005). Gupta (2000) made a similar conclusion to the effect that women with higher education and high standard of living are better off as they appreciate the health and social advantages of protecting themselves by delaying pregnancy. Young women especially, tend to postpone pregnancy until they have completed their education and feel that they are socially and economically secured (Jamieson and Buescher, 1992). Education serves as a resource that enhances economic opportunities and social mobility process that shapes attitudes, values and aspirations. 'Better educated women have more knowledge of contraceptive methods or how to acquire them because of their literacy, greater familiarity with modern institutions and greater likelihood of rejecting a fatalistic attitude towards life than uneducated women' (Oyedokun, 2007: 1).

#### **2.3.1.2 Educational attainment in Lesotho**

The Lesotho Reproductive Health Survey (2003) indicates that a higher level of education increases contraceptive use. Women with no education comprise 9 percent and 49 percent of those with secondary education who are using contraceptives (LHDS, 2004). LDS (2002) indicates that males and females with no education, 23 percent and 27 percent respectively used contraceptives while 59 percent of males and 57 percent of females who completed secondary education have used contraceptives. Education has been shown to influence women's ideology in favour of adoption of modern changes that bring about change in fertility behaviour. Mturi and Moerane (2001) indicate that in Lesotho, women have a higher educational attainment compared to their male counterparts. Never married educated women are shown to have a high prevalence of contraceptive use than those who are not educated and live with partners (Tuoane, Madise and Diamond, 2003). The reason being that premarital birth may jeopardize their chances of completing their education as they are the ones who bear the consequences due to expulsion from school for falling pregnant.

#### **2.3.2.1 Occupation status globally**

Shapiro and Tambashe (1994) portray that occupation levels increased the practice of contraception among sexually active women in Zaire. Furthermore, 26 percent of women who were not employed had ever used a modern method compared to 79 percent of those who were self-employed and 93 percent of those who were employed (Shapiro and Tambashe, 1994) add. This indicates that those who are employed have a high likelihood of



practicing contraception than those unemployed. The United Nations (1987) contends that modern occupation for young men and women plays an important role in influencing contraceptive use and reducing fertility. Resulting from their responsibilities and tight schedules, young people would want to control their fertility in order to maintain their professions and financial aspirations. Furthermore, occupation like education, gives women more control on family planning decisions including suppression of fertility as they base their lives to the prevailing economic changes. Women who are educated are able to get good satisfying jobs and this enables them to have control over their incomes. Oyedokun (2007) argues that a woman and partner's occupation were associated with the approval of contraceptive use in Nigeria. Female employment empowers women in decision-making including making a choice for the desired number of children. Occupation has a strong influence on contraceptive use because many women value paid employment and as such an additional pregnancy becomes a cost due to the loss of income.

#### **2.3.2.2 Occupation status in Lesotho**

Women are currently actively participating in the labour force. Most women in Lesotho are working in factories where they have to leave early in the morning for work and come back late in the afternoon, which gives them less time to look after their families. High contraceptive use in Lesotho is also influenced by partner's work status (Tuoane, Madise and Diamond, 2003). This may indicate knowledge of contraception among those who are working.

#### **2.3.3.1 Access to health services globally**

Accessibility and availability of contraception has an influence on family planning services among young men and women. This makes women decide on what methods of contraception to use. Thang and Anh (2002) and Meekers and Klein (2002) showed that Vietnam and Cameroon had experienced an increase, about 95 percent in contraceptive use because facilities providing family planning services were only one kilometer from their clients. Moreover, 84 percent find family planning services in their communities from sources such as community health based providers. Kibagu and Zabin (1995) and KDHS (2003) state that in Kenya, 90 percent of respondents who were using contraceptives knew that they could obtain contraceptives at a clinic while 61 percent of females who did not use contraceptive did not know where to go for family planning services.

Inaccessibility is an issue because access means many things such as possibility of getting to the service point, the cost, waiting hours and knowledge of where to obtain the service. Hennink and Madise (2005) indicated that most of African countries are faced with financial problems because of the reduction from donor funding which led them to charge their clients in order to generate revenue to expand health service facilities. This will have an impact on contraceptive use as poor people will not afford to pay. For example, a 32 percent decline in client numbers was observed in Swaziland after the Ministry of Health increased prices by 300-400 percent. Again, in Bangladesh there was a 29 percent drop in condom sales because of a 60 percent condom price increase (Hennink and Madise, 2005).

Blanc, Curtis and Croft (2002) points out that quality of family planning care is an important indicator of contraceptive continuity and enhances good care by satisfying clients' needs and improving their services. An example is given of Morocco where different scholars have found a positive association on the availability of methods in local facilities, 'the availability of the pill in local pharmacies and of the level of family planning infrastructure and equipment in local facilities increased the use of modern contraceptives' (Blanc, Curtis and Croft, 2002:128). In addition, Stephenson, Beke and Tshibangu (2008) state that in communities where health centres have more staff and where they can offer more services like counselling before providing clients with contraceptives, that is commitment of staff is associated with availability of services anytime. RamaRao, Lacuesta, Costello, Pamgolibay, and Jones (2003) indicate that women who are living in high-quality environments are more liable to practice contraception. Evidence from West Africa, China and India showed that young people who receive more counselling and information about reproductive health increase use of contraceptives (RamaRao, Lacuesta, Costello, Pamgolibay and Jones, 2003) add.

#### **2.3.3.2 Access to health services in Lesotho**

Community based programs can be the solution to bringing health services closer to contraceptive users. In areas with reliable health services there is high contraceptive use because they are easily accessible and in most cases available (Tuoane, Diamond and Madise, 2004). In addition, Tuoane, Madise and Diamond (2003) assert that women who stay near health services are more likely to use contraceptives than those who have to travel hours to reach a service point. Quality of service is the key component to influence and increase

contraceptive adopters by providing a range of contraceptives to clients. In the study by Tuoane, Diamond and Madise (2004), the focus group discussants pointed out those women had stopped attending family planning services because of lack of privacy; only a counter separated them from other patients. Moteetee (2005) further indicated waiting time as another factor that had impact on access of contraceptive use by young women. Clients have to wait about six hours before they could be served which becomes inconvenient for young women as some of them were still attending school (Moteetee, 2005) adds. However, this is not surprising due to the fact that many health facilities as well as hospitals are understaffed; therefore, this situation limits young women access to contraceptives and thus leads them to opt for other means like using unauthorized liquids (spirit).

#### **2.3.4.1 Knowledge, use and information availability globally**

The study conducted in Nigeria indicates that knowledge of at least one method of contraceptive had increased contraceptive use in young men and women and was estimated at 74 percent (Oni and McCarthy, 1990). Furthermore, Gage-Brandon and Meekers (1993) state that studies conducted in Botswana, Kenya and Zimbabwe showed that 90 percent of sexually active unmarried women know at least one modern method. Agyei and Epema (1992) and Kalk, Kroeger, Meyer, Cuan and Dickson (2001) show that knowledge and awareness of contraceptives is high at 86 percent males and 83 percent females. Teenagers who reported using contraceptives consistently constituted 63 percent with 69 percent and 59 percent of males and females respectively in their first sexual relationship compared to 16 percent that were inconsistent and 21 percent who had never used contraception (Manlove, Ryan and Franzetta, 2003). KDHS (1993) indicates that knowledge about family planning methods had shown an increase from 88 percent in 1977/78 to 96 percent in 1993. The most predominant method used among teenagers was the condom accounting for 80 percent ((Manlove, Ryan and Franzetta, 2003). On the other hand, Green, Bardelez, Daniel, Rodrigues and Romero (2000) pointed out that the study conducted in Mozambique showed the pill and injectables as the most used method with 89.4 percent.

Health education and access to information increases the use of contraceptives because women become familiar and get knowledge about family planning, and also accept it. According to Fikree (2001) approximately fifty percent of women using contraceptives in Pakistan were influenced by family planning messages they got from health providers as well

as mass media. In addition, Meekers and Klein (2002) argued that Cameroon was successful in increasing condom use among young people through its programme called “100% Jeunes”. Parental support and discussion about family planning with young men led to the increase in condom use (Meekers and Klein, 2000). Moreover, Kane et al (1993) argue that in Gambia knowledge of at least one method of contraceptive is very high with 76 percent of young people reporting that condom is the most effective and efficient method of contraception for people of their age. These single men and women reported that condoms are easier to access and prevent both unwanted pregnancy and STIs including HIV/AIDS and they are used privately as most of them have attended family life education, FLE, (Klein et al, 1993).

High educational attainment with exposure to television is highly allied with high contraceptive use (Gupta, 2000; Oni and MacCarthy, 1990). Gupta (2000) indicates that ‘In Brazil, television programming for linguistically homogenous populations, particularly the highly popular soap operas has been credited with playing a substantial role in promoting ideological change with respect to reproductive behaviour by portraying lifestyles that favour delayed childbearing and smaller families’ (p. 231). High levels of care lead to greater influence for young people to use modern methods of family planning. RamaRao, Lacuesta, Costello, Pamgolibay and Jones (2003) states that 61 percent of women whom their needs were assessed used modern methods compared to 51 percent of those who did not. This indicates that when young people understand their needs and have social support are likely to change their behaviour and the adoption of contraceptives. According to Debpuur (2002) in communities where there is out-reach of nurses to clients there is high knowledge of modern methods of contraceptives. This indicates that where programs were well organized and implemented, contraceptive distribution and use can be highly consistent.

#### **2.3.4.2 Knowledge, use and information availability in Lesotho**

Lesotho Demographic and Health Survey, LDHS (2004) and LDS (2003) indicate that a high percentage of young people in Lesotho know or have heard of a modern method of family planning even if they had not used it. The report further shows that 99.5 and 99.1 percent of women and men respectively know at least one method of contraceptives. The most known method among both men and women is the male condom, accounting for 97 percent (Tuoane, Madise and Diamond, 2004). About 86 percent of the young sexually active adolescent reported to having used a male condom at some point (LDHS (2004); LDS (2003); Ministry

of Health and Social Welfare, 1994). Tuoane, Madise and Diamond (2004) also pointed that flip charts and posters are the mostly used materials to deliver information about family planning methods available at the clinic accounting for 84 percent of the information provided through the media. While the focus groups from the study stated that there are disadvantages concerning the system because it does not cater for people who are illiterate. Moreover, nurses still have to elaborate more before they can let the client to choose the preferred contraceptive method.

LDHS (2004) found that family planning information was mostly obtained through the media whereby the majority stated radio as their main source. The report further portrays that urban residents reported their main source of information about modern methods as television and men reported newspapers or magazines. Tuoane, Madise and Diamond (2003) indicate that never married young people are more likely to use contraceptives than their married counterparts by 52 percent. The reason for this observed differences being the prevention of unwanted pregnancies while others were afraid of not getting married as well as fear of premarital birth.

#### **2.3.5.1 Method choice globally**

Condom was the predominant method of choice whereby 60 percent of Whites and 75 percent of Blacks in the United States responded using them (Manlove, Ryan and Franzetta, 2003). Moreover, Kalk, Kroeger, Meyer, Cuan and Dickson (2001) pointed that 69 percent of men in Nicaragua showed that they got explicit instructions on how to use a condom. A combination of female-controlled barrier methods (female condoms with or without spermicides) was chosen together with male condoms by young women and men with 57 percent and 46 percent respectively in San Francisco for prevention of pregnancy (Minnis and Padian, 2001). High rates of contraceptive use were found to be in communities where health providers give women the opportunity to choose their preferred method of contraception (Hogan, Astone and Kitagawa, 1985). Blanc, Cutis and Croft (2002) reached similar conclusion stating that clients, who receive the method of their choice, as choice has a strong influence on contraceptive pattern of the community, increased the continuation of contraceptive use in Indonesia. This is because they build up trusting relationship with staff and it enables them to be open. Adequate counselling about benefits and consequences of contraceptive was influential in Gambia and Niger (Blanc, Cutis and Croft, 2002).

### **2.3.5.2 Method choice in Lesotho**

LDHS (2004) indicates that about 36 percent of current contraceptive users did not have a variety of choice of method they want to use and were also not informed about the side effects of modern methods. The study conducted by Tuoane, Madise and Diamond (2004) found that there is a limited choice of modern methods as participants in focus groups were complaining that there is only one type of pills in most of the clinics or sometimes condoms are out of stock for a long period. This implies that clients use the methods they do not like because of the intention to prevent pregnancy. Family planning clients who have been provided with knowledge of side effects of the methods are able to choose the one they prefer.

### **2.3.6.1 Attitudes of Health providers globally**

In some countries such as South Africa with its effort of establishing youth clinics, providers seem to have negative attitudes towards young women and men in providing them with good service (Kaufman, de Wet and Stadler, 2001). This inhibits utilization of contraceptives and lead to high pregnancy rates. In Asian countries even married adolescent encounter problems when seeking fertility regulations (Pachauri and Santhya, 2002). Young people faced providers' resistance to provide them with contraceptives due to providers indicating that they are prohibited by cultural norms and morals, which do not allow adolescents to use contraceptives. Evidence from Bangladesh, Vietnam and Nepal showed that field workers did not visit adolescent females. In addition, Dehne and Riedner (2005) asserts that other barriers that lead to adolescents not to utilize health service is the fact that young people are being served in the same health centres with adult people (their parents in short) which can make them feel embarrassed. Studies in Benin and Zimbabwe showed that lack of privacy and confidentiality resulted in discontinuation of contraceptive use among adolescents (Ezimokhai, Ajobor, Jackson and Izilien, 1981; Kim, Marangwanda and Kols, 1997).

Furthermore, the timing for services is not convenient for them as they are at school at the opening time. This can result in adolescents' having unsafe abortions which can end with maternal death of these young women or ineffective treatment of infections due to late presentation (Makatjane, 2002; Kaufman, de Wet and Stadler, 2001; Gage-Brandon and Meekers, 1993). This become a health concern because even in countries where abortion has been legalized, adolescents still opt for unsafe abortion due to obstacles in clinics that are allowed to perform it. Moreover, they state that complications from incomplete abortions

accounted to one-fifth of the maternal deaths and have become the leading cause of death in many countries.

#### **2.3.6.2 Attitudes of health providers in Lesotho**

Tuoane, Madise and Diamond (2004) indicated that in Lesotho young women were discouraged by providers' bias, where they would pay more attention to their friends over the rest of them. Furthermore, other adolescents indicate that access to contraceptives at the family planning services is not easy as control methods are not available for them most of the time; and again they are afraid to be seen by older people (Mturi and Moerane, 2001; MOHSW, 1994). While in contrast, parents indicated that adolescents are not discriminated at the family planning services because they get services just like them (Reproductive Health Research, 2001; Mturi, 1999).

#### **2.3.7 Disapproval of family planning and contraceptive use**

It was reported that men have a negative attitude towards contraceptive use in Lesotho (Makatjane, 2007). Santhya (2003) argue that this was because when family planning was introduced it was integrated into the maternal and child welfare clinics that were attended by women only. This implied that men were left out yet they have a major role in decision-making in the family. According to Makatjane (2007) the commonly cited reason is men feared that there is the likelihood of infidelity by their wives or promiscuity. Disapproval of contraceptives by men leads to low contraceptive use, which shows that women's lack of autonomy still exists in Lesotho. This was also the case in Ghana where women who practiced contraceptives suffered social ostracism or family conflict (PRB, 2007). Whereas in South Asia because of preferences of sons, married adolescents suffer pressure from the community and extended family to have children even if their partners wanted to wait (Pachauri and Santhya, 2002).

#### **2.3.8.1 Parents and Partners' communication globally**

Fikree (2007) states that spousal communication in Pakistan was very essential in increasing contraceptive use whereby 85 percent of men and 84 percent of women indicated communicating family planning methods with their partners. About, 51 percent of the United States adolescents' have discussed family planning with their partners' before engaging in

sexual activities for the first time (Manlove, Ryan and Franzetta, 2003). The study conducted in Cameroon indicated that young people, 72 percent of males and 67 percent of females stated getting support from their parents on the use of condoms (Meekers and Klein, 2002). Recently scholars have recognized the importance of including men in the decision-making of family planning behaviour to enhance partner communication. Fikree (2001) argue that lack of communication between partners about safer sex seems to be one factor that impedes new contraceptive use. Moreover, a positive relationship of high contraceptive use was also observed because of discussions and agreements of family planning among couples.

Meschke, Barthomae and Zentall (2000) and Jaccard and Diittus (1993) contended that boys and girls who have discussed family planning methods and approved it have high contraceptive use especially those who are also able to discuss birth controls with their parents (mothers). In Pakistan, communications between young married adolescents with their mother-in-law has improved contraceptive use among them (Fikree, 2007). This might show that partner as well as parent-adolescent communication is related to increase in contraceptive use and new ideas can be introduced. Furthermore, evidence from India supports the idea of communication as the effect of diffusion theory has led to a decline in fertility in this country (McNay, Arokiasamy and Casses, 2003). Furthermore, McNay, Arokiasamy and Casses indicate that the presence of literate males has influence on contraceptive use as they teach their partners about their benefits and where to get them. It can be said that uneducated young people copy those who have knowledge about contraceptives even though they are from poor socio-economic settings as such they adopt the behaviour.

#### **2.3.8.2 Parents and Partners' communication in Lesotho**

The LDHS (2004) and LDS (2003) indicates that communication of family planning among couples is very low with 63.7 percent of those who does not communicate at all to 46 percent of those who responded to had participated in decision-making regarding family planning. In Lesotho couples experience lack of communication due to dependency on tradition in which; sexual intercourse issues are sensitive and are not discussed often. This is especially true for women who may feel embarrassed to discuss such issues with their partners (LRHS, 2002). In addition, religious beliefs also contribute to this lack of communication because children are seen as a blessing from God, and an attempt to control childbearing is not accepted by



some religious groups (Fikree, 2001). However, in Lesotho there is confusion on the parent-adolescent communication as some parents think it will change adolescents' behaviour as they respect what their parents told them (Mturi, 2003). While on the other hand, other parents are against it because they are afraid that it would encourage promiscuity and are scared of helping them with homework' relating to sexual issues (Mturi, 2003). In contrast, UNAIDS (1997) argues that evidence from studies in the intervention of sexual health education on young peoples' sex behaviour showed a delay in the onset of sexual activities which led to reduction in unintended pregnancy. Reproductive Health Research (2001) showed that many parents in Lesotho indicated that they only discuss sexual issues accidentally such as when formal prompted by a TV programme. In addition, Mturi (1999) states that many parents encouraged sex education so that the burden is left with teachers who will provide adolescents with reproductive health knowledge.

#### **2.3.9.1 Place of Residence globally**

Evidence shows that contraceptive use influence is higher in urban areas than in rural areas. About 89 percent of adolescents' residing in urban areas has access to family planning services (Thang and Anh, 2002). KDHS (1993) indicates that contraceptive use is higher in urban areas with 43 percent than in rural areas with 31 percent. According to Robinson (2008) this can be the case because urban adolescents are more nearer to health services than those who are living in the rural areas. Again, urban adolescents are likely to use modern methods as they have a greater access and availability of family planning services (Gupta, 2000). Another reason is that urban people value education first than having many children while their counterparts in the rural areas are still burdened by tradition of getting married after a certain age. Kane et al (1993) asserts that in Gambia most of the adolescents have modern outlook on contraceptives because most of them grew up in urban areas and had better knowledge of fertility regulations. Gage-Brandon and Meekers (1993) indicated that urbanization and modernization have been associated with decline in fertility and increase in premarital sex as it has undermined traditions, norms and morals of many African societies. Virginity before marriage is no longer regarded as pride for girls. As for men nowadays, childbirth is the requirement of marriage; it is an assurance of potential to have children in the future (Gage-Brandon and Meekers, 1993; Kaufman, de Wet and Stadler, 2001).

However, USAID (2005) and Addai (1999) showed that young people in rural areas are not able to access contraceptives because of lack of roads in the rural areas. They may also have low contraceptive use as they have negative attitudes about contraceptives such as untrustworthiness of partner or causing infertility, thus they have not accepted family planning methods. While young urban people because of modernization, are able to adapt to change of behaviour occurring in populations. Thang and Anh (2002) argue that in most countries family planning centers are situated in urban areas which lessen the use of contraceptives in the rural areas. In Vietnam the project of family planning provided urban women with access to modern methods. Again, public awareness is another obstacle facing low contraceptive use in rural areas because most of the time media (radio, television) are not accessible in these areas.

The study conducted in Peru found that 70 percent of women in rural areas had low quality of health care compared with 66 percent urban dwellers that get high quality of health care resulting in greater contraceptive use in this high quality of care (Mensch, Arends-Kuenning and Jain, 1996). In contrast, Robinson (2008) indicates that in some areas family planning have expanded to the rural areas successfully. In addition, Robinson states that in Thailand, which is known of its strong family planning programmes, effective and availability of contraceptives were higher in the rural areas. In Indonesia family planning clinics are of greater services in the poor rural areas than the urban areas. This is similar to Nigeria whereby after a five-year project to extend coverage of family planning services there has been universal increase in contraceptive use across all segments of the population (Oni and McCarthy, 1990). Mensch, Arends-Kuenning and Jain (1996) show that in Lima, Peru large public health hospitals and health-care centers are found in the poorer areas.

#### **2.3.9.2 Place of residence in Lesotho**

Women in urban areas are more prone to contraceptive use constituting 50 percent compared to 34 percent of those from the rural areas (LDHS, 2004). Mturi (2003) argue that in Lesotho due to modernization, practices that used to discourage premarital sex are no more strictly practiced such as checking brides' chastity immediately after consummation of marriage. LDHS (2004) indicates that due to the topology of the country urban people are more likely to use contraceptives than those in the rural areas. This is due to lack of infrastructures in the rural areas where one would find that even one clinic that is available serves different villages

which are far apart from one another, thus people become tired of walking long distances to get family planning services. Tuoane, Madise and Diamond (2004) argue that in Lesotho provision of family planning services is not easily accessible in rural areas because they have to walk long distances on foot or even where transport is available it is very expensive. Most of the LPPAs clinics are based in the urban areas which enables young women and men to have easier access to family planning services than their counterparts in the rural areas (Tuoane, Madise and Diamond, 2003).

#### **2.3.10 Peer Pressure**

Kiragu and Zabin (1995) and Meckers and Klein (2002) showed that 49-85 percent of males and 42-79 percent of females used contraceptives through the influence of their friends. A proportion of 25 percent and 28 percent of males and females respectively used contraceptives at their first sexual intercourse. Most respondents, 31 percent reported friends as their main source of discussing contraceptives use (KDHS, 1993; Kalk, Kroeger, Meyer, Cuan and Dickson, 2001). According to Juarez and LeGrand (2005) adolescence is the time when young men and women start to identify romantic and sexuality bonding as well as time for ongoing learning and experimentation. It is the time of transition from childhood to adulthood and it has to be under a good environment. Sometimes young people do things to please their friends. Juarez and LeGrand (2005) add that young people are susceptible to social norms especially young men where they have to show their masculinity, satisfy their curiosity as well as to prove their manhood. They use contraceptives because of fear of pregnancy and often the desire to prevent sexually transmitted infections (STIs) including HIV. Most of young couples are likely to use temporary contraceptive methods as they still have the intension of having children in the future (Edmeades, 2008).

In Kenya, many students use contraceptives because they get supplies from their friends who give them pressure to experience sexual activities (Kiragu and Zabin, 1995). Others are motivated to use contraceptives because of consequences that are encountered by girls who fall pregnant while still at school (Kiragu and Zabin, 1995). Juarez and LeGrand (2005) assert that boys also indicate that they were influenced to use condoms because mostly their first encounter was with prostitutes or unsteady girlfriends, thus they sought to protect themselves from diseases. Casterline, Montgomery and Hewett (2002) argue that it is normal that most people adopt the behaviour and attitudes of others. Adolescent without knowledge of the

benefits and risks of contraceptives use usually rely heavily on the experience of their peers implying that reproductive behaviour of many people is influenced by their peers. Studies conducted in South Africa, Zimbabwe and Tanzania indicates that most of adolescents' depend on their friends as the main source of information regarding STIs and use of contraceptives (Dehne and Riedner, 2005).

### **2.3.11 Social networks**

Social networks also influence knowledge and use of contraceptives because as people interact there is sharing of information, gathering of positive experiences from those who have used modern method earlier allowing adoption of these new behaviours (Stephenson, Beke and Tshibangu, 2008). In addition, the belief by a community is influential in the use of a certain contraceptive or the most likely promoted method mix and this enables women to have a choice in the methods. Pachauri and Santhya (2002) indicate that in India the most commonly known method was tubal sterilization because it was promoted by a national program.

### **2.3.12.1 Religion globally**

Addai (1999) indicates that about 95 percent of Protestants and other Christian respondents knew about modern methods than their counterparts Catholics and Moslems. In addition, 90 percent of them have used family planning methods than other religions. White fundamentalists Protestants account for 62 percent who have used contraceptives compared to 60 percent of Black fundamentalists Protestants than Catholics and other religions (Brewster, Cooksey, Guikay and Rindfuss, 1998). Furthermore, 60 percent of Whites and 46 percent of Blacks used contraceptives at their first sexual intercourse where condoms were the predominant method of choice. Conversely, in Mozambique the highest contraceptive use was among the Catholics with 36.3 percent while Protestants constituted 19.8 percent and Muslims accounted for 15.5 percent (Green, Bardelez, Daniel, Rodrigues and Romero, 2000).

In most countries, religious affiliations are totally prohibiting contraceptive use let alone to young people as they are not expected and encouraged to engage in sexual relations. However, there are others who are more adaptive to changes in people's behaviour. Addai (1999) states that the Catholic Church is known to be explicitly and consistently against family planning and abortion. In addition, the Muslim faith also oppose contraceptive use as

children are considered to be the richest blessing granted by Allah. They believe in marriage and motherhood as the status of women (Addai, 1999). However, Brewster, Cooksey, Guikey and Rindfuss (1998) shows that in other countries among women who had used condoms at their first encounter were from the Catholic Church. The Catholic Church is likely to provide work alternatives and other methods. For example, in Mozambique the Catholic Church is said to support contraceptive use as nuns and nurses provide pills and information to church members, they are against abortion only (Agadjanian, 2001). Moreover, in Brazil where teenagers attending different denominations including the Catholic Church have indicated high contraceptive use during sexual initiation compared with non-attendees. Gupta (2000) pointed that because of Catholic Church deteriorating influence on birth controls, teenagers have sexual freedom in practicing premarital sexual activities.

Protestants and Christians are said to have an influence on the contraceptive use as they are found to be more adaptive to the local customs and practices (Addai, 1999; Agadjanian, 2001). Bongaats and Watkins (1996) state that recent demographic research has shown that secularization influences and pushes reproductive behaviour and diminishes the religious empire. Another reason pointed out was that this is because most of Protestants women followers are at their reproductive ages and working in the formal sectors and that they might view high fertility to lead to overpopulation and becomes a social problem. Agadjanian (2001) argue that parishes are also the determinants of residential segregation as most affiliations with many attendees' are situated in the cities. This is where better educated and wealthy people attend and are more westernized than those in small townships where most of the poor people are located. Furthermore, Brewster, Cooksey, Guikey and Rindfuss (1998) pointed that when differentiating by race, black churches seem to be more communalistic, thus they are sympathetic and forgiving which shows good morals.

#### **2.3.12.2 Religion in Lesotho**

In Lesotho, the Catholic Church is against artificial family planning and they do not allow such services in their hospitals and healthcare centres (Tuoane, Diamond and Madise, 2004; Letuka, Matashane and Morolong, 1997). The Catholic Church prohibits childbearing out-of-wedlock. Makatjane (2002) indicates that other Christians are more likely (1.3 times) to have experienced premarital child birth than the Catholics and may not be very strict with contraceptive use.

### **2.3.13 Self-efficacy**

Longmore et al (2003) define self-efficacy as the inspiration to augment contraceptive use to sexually active individuals. This implies that individuals are able to confidently find it important to negotiate safe sex on their own without being influenced by others. This means that individuals can execute a change of behavior and can have safer sex. In Ghana, men who reported high levels of contraceptive use were those who were confident in negotiating and convincing their partners to have safe sex which led to consistent and correct use of contraceptives (Meekers and Klein, 2002). Moreover, 86 percent of males and 80 percent of females were confident that they could convince their partners to use contraceptives when having sex. Three quarters, 77 percent of males and 55 percent of females were certain that they knew how to use condoms correctly. High self-esteem is associated with greater influence in contraceptive use as it needs actual negotiation and availability.

Adolescents make their own decision to use contraceptives because they know that sex instigation was about to happen, preventing instead of waiting for cure. In Namibia they used curriculum based training to try to increase women's self-esteem so that they can control their sexual relationships, be able to protect or negotiate safer sex from aggressive men who are also older than them (Gueye, Castle and Konate, 2001). Perceptions and attitudes of adolescents towards an intention to perform a behavior play a role in building ones self-efficacy. Social support has been reported to influence adolescent girls in Zimbabwean to use contraceptives as they do not have to worry about other people knowing that they are methods adopters (Meekers and Klein, 2002; Herold and McNamee, 1982).

In order to maintain the health of young people as they are the future generation for development and economic growth of countries, there is need to expand access to family planning. Sexual and reproductive programs to demonstrate the problems facing young people with premarital sexual activities without protection, may be useful as they will encourage them to use methods in every sexual act to prevent STIs and HIV as like in other countries where peers are the ones disseminating contraceptives. There has to be a change of attitude by providers' regarding access to services and must improve quality by providing information concerning young people's reproductive health needs. If they keep on humiliating these young women it complicates matters where women opt for unsafe abortions which lead to maternal deaths. Dehne and Riedner (2005) pointed out that attitudes of

providers may lead to infections being treated when they are at critical stage or when they may not be treated at all which could have been prevented.

Again, cultural change to modern health care can enable women to communicate and enable to negotiate safe sexual relations as well as to participate in decision making of reproduction issues. USAID (2005) indicates that low literacy and high rates of school dropout because of unintended pregnancy or HIV/AIDS has an effect in young people's contribution to economic development as well as self-development. The observation in recent years is that young people spent a long time in school and employment afterwards which delays age at first marriage. However, young women are engaging in sexual activities indicating that there has to be action taken to avoid these pregnancies as they become a burden to parents and the government.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

The aim of the study is to examine factors influencing contraceptive use and the actual contraceptive practice. This study will examine the levels of contraceptive use among young women in Lesotho, both social and demographic characteristics and additional factors that can act to encourage or discourage contraceptive use. This is because many studies conducted in Lesotho shows that there is a high level of knowledge of modern contraceptives but the level of use is still lagging behind. Lesotho like other developing countries is experiencing high premarital pregnancies. For the purpose of this study, the analysis was based on sexually active women aged 15-24 years. Therefore, a sample size of 3,217 women aged less than 24 years old has been used.

##### **3.1.1 Choice of the study population**

Lesotho is one of African countries with poor economy and the distribution of wealth has a wide margin between the rich and the poor. In an African setting women have been considered as minors, thus they were not allowed to take any decisions concerning reproduction without their partners' permission. Lesotho like other developing countries has adopted the Constitution of Gender equity and equality that was reflected at the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women held in Beijing. This is by promoting women's rights including the individual power to access family planning with the aim of controlling fertility outcomes. It gives women self-esteem especially the youth to be active and productive citizens of the country. The Department of Gender under the Ministry of Gender and Youth, Sports and Recreation mandate is to enhance equality of gender issues between men, women, boys and girls into national policies and programmes. Therefore, the 2004 Lesotho Demographic and Health Survey was conducted for thorough information on the populations' health and developments by providing timely and updated data to monitor population and health in Lesotho as it was the first national-level population and health survey in the country.



### 3.2 Data Source

Lesotho Demographic and Health Survey (LDHS) was conducted by the Ministry of Health and Social Welfare (MOHSW) in collaboration with the Bureau of Statistics (BOS). Macro International furnished technical assistance for the survey. According to the Lesotho Demographic and Health Survey (2004) more than 9,000 households were selected for interviews to represent the whole country. This was done in order to allow for separate estimates for the indicators among all ten districts and for urban and rural areas. The response rate was very high with 94 percent of women and 85 percent of men and was successfully interviewed. The report indicated that the low response rate for men might reflect that men are most of the time absent from their homes because of their employment status and life style (LDHS, 2004).

Lists of 405 enumeration areas were developed from the 1996 population census frame at the time of the survey. A two-stage sample design was utilized for selection of participant household in the survey. The first stage was the selection of clusters from the 1996 population census frame, divided into rural and urban areas. At this stage clusters were randomly selected, thus each cluster had an equal chance of being selected. The second-stage comprised listing of all households from selected clusters, and then systematic sampling was used for selection of individual households to be interviewed in the survey. Women aged 15-49 and men aged 15-59 residing in the rural and urban areas were eligible for interview. In every second household selected, all men and visitors of the household aged 15-59 years were eligible for the interview. These eligible men and women were taken few drops of blood for the purpose of establishing their HIV status. Furthermore, in these selected households, children under the age of five were taken the height, weight as well as tested for HIV/AIDS. Informed consent was given by parents for their children.

Three questionnaires were used to conduct the 2004 LHDS which were the Household questionnaire, the Women's questionnaire and the Men's questionnaire. The household questionnaire recorded all usual household members and visitors in a selected household. It further collected information on characteristics of each individual including age, sex, education, residence and emigration status and their relationship to the head of the household. Survival status of parents for children under 18 years was collected. The Household

questionnaire's main aim was to identify men and women who were eligible for individual interview. Furthermore, the questionnaire gathered information on the characteristics of the dwelling unit such as the source of water, type of toilet facilities, material used for the floor and roof, ownership of various durable goods and access to health facilities. The questionnaires were piloted before the survey to check how long it took to finish one questionnaire and whether the questions were clearly stated and easily understood.

The LDHS (2004) further indicated that women questionnaire collected information from women aged 15-49 in the survey. Each woman was asked questions on background characteristics (for example age, education, media exposure and residential history), birth history and childhood mortality, knowledge and use of family planning methods, fertility preferences, antenatal and delivery care, breast feeding practices, vaccinations and childhood illness, marriage and sexual activity, woman's work and husband's background characteristics, awareness and behaviour regarding AIDS, other sexually transmitted infections (STIs), tuberculosis (TB) and maternal mortality. The aim of the women questionnaire was to examine the impact of women's access to family planning services on contraceptive.

The interest is to find whether women are aware and use family planning methods to prevent unplanned pregnancies and STIs including HIV. Moreover, whether they have the opportunity to access family planning services at all times of need especially those in the remote, hard-to-reach rural areas. This was explored by questions such as: have you ever heard of method of family planning that would show their knowledge about birth controls. Ever use of method of family planning was determined by questions like: have you ever used and are you currently using any family planning method to prevent or delay pregnancy. It further assesses knowledge of the source of obtaining contraceptive methods. Use of condoms at last sexual intercourse was also examined especially in order to test its effectiveness. The sample size of 3,217 young women aged 15-24 years will be used in this study. Women aged 15-19 account for 1,761 women and 1,456 are women in the age group 20-24 years.

Men's questionnaire was much shorter than the Women's questionnaire though it captured more or less the same information because reproductive questions on child health, nutrition and maternal mortality were not asked. In addition, the study tested all eligible men and

women for haemoglobin and HIV/AIDS. Haemoglobin testing was done to check for anaemia from the blood and a consent form was issued as to ask for permission from the respondent to proceed with the process. For HIV testing, respondents were given a description of the testing procedures and that testing will be anonymous and confidential. Consent was read to the respondent and signed before commencement of the process, and for respondents aged 15-17 it was obtained from the parents or guardian by trained interviewers. The protocol for haemoglobin and HIV testing was approved by the Lesotho Ministry of Health and Social Welfare Ethics Committee in Maseru and the ORC Macro Institutional Review Board in Calverton, Maryland, USA. This study took an approach of examining young peoples' influence on contraceptive use. Interviews were conducted in the local language, Sesotho. Data collection took approximately four months from 28 September 2004 to 18 January 2005.

### **3.3 Measures**

#### **3.3.1 Dependent variable**

The study is aimed at understanding how modern contraceptive use can be influenced by factors such as woman's age, educational attainment, place of residence, accessibility and availability of health services and others. Respondents were asked about their social and demographic characteristics, sexual activity and contraceptive use. Questions assessing their knowledge of, attitudes and access to contraceptives were also incorporated. This study examines to what extent accessibility and availability of family planning services to sexually active adolescents' affected their likelihood to use contraceptives. The observed outcome is contraceptive use, and key determinant of interest is access to family planning services. Since the DHS targets women in their reproductive ages, and has an adequate sample of 3217 women in teenage years, it provides a useful tool to understand contraceptive behaviour of this group. The DHS asked women a range of questions about their contraceptive practice:

- ❖ Have you ever used any method of contraception?
- ❖ Are you currently using any method to delay or avoid getting pregnant?
- ❖ Do you know a place where you can obtain a method of family planning?
- ❖ The last time you had sexual intercourse, was a male or a female condom used?
- ❖ What was the main reason you used or did not use a condom that time?

The questions that are used in this study to explore and quantify contraceptive use are:

- ❖ Have you ever used any method of contraception?
- ❖ Are you currently using any method to delay or avoid getting pregnant?
- ❖ Which method are you currently using where women were allowed to indicate more than one method?
- ❖ The last time of sexual intercourse, was a condom used?

Two indicators determine contraception: contraceptive use and method choice. The analysis will be approached in two stages; the first stage it examine the determinants of contraceptive use. This is captured by data gathered from young people who reported being sexually active at the time of the survey. Rimal (2003) argue that contraceptives are used with the aim of preventing unplanned pregnancy, child spacing or delaying childbearing. Therefore it is essential to concentrate on young sexually active adolescents (those who ever had sexual relationships). The benefits of contraceptive use are also on the maternal and child health because of complications teenagers face during pregnancy and delivery as their bodies might not be mature enough to carry the child full term (Blanc and Way, 1998; Glasier, Gulmezoglu, Schmid, Moreno and Van Look, 2006). Moreover, it can also prevent high levels of abortions that adolescents' opt as the solution to their unplanned pregnancies.

The second analysis is on the method of choice among young sexually active adolescents' who are using contraceptives. Choice of contraceptive method is determined by the method that sexually active women reported using at the time of data collection. The question was selected because it shows the most method used by teenagers. Moreover, it examines the reasons or influences for the most preferred method and the characteristics of these young people who are using a specific method. Stephenson, Beke and Tshibangu (2007) reported from their study in Eastern Cape that choice of method was influenced by social networks as women from same villages could choose methods that are used by women who are already contraceptors. It can also be argued that the choice of method is more influenced by medical practitioners and clinical nurses according to how they inform their clients about the advantages and disadvantages of the methods. When there is a wide variety of contraceptive methods provided, clients are given an opportunity to identify the method they prefer according to their characteristics and this increases contraceptive use (Indongo, 2007; Hamid and Stephenson, 2006).

Furthermore, a wide range of contraceptives is the answer to women's reproductive rights as expressed at the 1994 International Conference on Population and Development (ICPD).

The last question is used to compare adolescents' who used condoms at last sexual intercourse to those who did not use condoms, to ascertain consistency of condom use. The analysis is to explore factors that are associated with condom use or non-use among young women. Ryan, Franzetta and Manlove (2007) in their study found that men did not use condoms in their first sexual intercourse which put their partners at risk of unintended pregnancy. However, Blanc and Way (1998) and Agyei and Epema (1992) argue that the reason why young people do not use condoms in their first sexual intercourse is due to lack of knowledge, inability of women to negotiate sex and inaccessibility of sources of modern methods. Adolescents' in their last sexual intercourse used condoms because of self-efficacy and change of behaviour (Meekers and Klein, 2002). Most of them are now informed about family planning and with an intention to have safe sex they are able to convince their partners to use condoms. Nevertheless, Cleland and Ali (2006) and Feldman and Maposhere (2003) in their studies found that about 79% of women preferred condom use as it has become a dominant contraceptive method due to its dual protection against unwanted pregnancy and HIV transmission.

The study in Uganda showed that consistent condom use with non-cohabiting partner increased from 5% in 1987 to over 60% in 2002 hence led to a decline in the HIV prevalence (Okware, Kinsman, Opio and Kaggwa, 2005). Feldman and Maposhere (2003) indicated that condoms can also be regarded to have triple protection because they also prevent re-infection to those who have been diagnosed with HIV. In their study in Zimbabwe, Feldman and Maposhere (2003) reported that HIV positive women were happy with condom use because of the society's perceptions that people with their status should not be sexually active. Adolescents' age at first sexual experience have impact on their future that leads to multiple relationships, thus condoms are used as a robust method to prevent the epidemiological risk of transmission from both casual and stable partners (Hearst and Chen, 2004; Gueye, Castle and Konate 2001; Nare, Katz and Tolley, 1997). Fergusson, Linskey and Harwood (1994) showed that these findings are consistent with literature which showed that knowledge of sexual health risk and lack of access especially in these age groups is not a good predictor of condom use.

### **3.4 Explanatory factors**

#### **3.4.1 Accessibility and Availability of contraceptives**

Accessibility of family planning means the point that appropriate contraceptive methods are available and whereby those seeking contraceptives can obtain services. It can be measured by the distance from the household point to the service point which measures the ability to physically reach the service provider/station. In this case it was measured using number of health facilities offering family planning within a district. In the mountainous districts of Lesotho, villages are structured in the manner that there is a wide dispersion between one another, then health centers are few and far from other villages. This situation makes it difficult for many young women to obtain contraceptives and lead to discontinuation to those who were using or no new comers for that matter.

Moteetee (2005) study confirmed the analogy that distance in the mountainous areas was a problem due to inavailability of health facilities irrespective of any mode of transport used. Moreover, cost was another barrier especially after an increase in the cost of contraceptive methods in 1998 because young women have to save money for transport and fees for the methods (Tuoane, Diamond and Madise, 2004). At least one fixed service point has to be more than one kilometre away (Thang and Anh, 2002). With regard to this definition, the results thus far show that women who are near the family planning service point have a high percentage of modern contraceptive method use than those who live far from the health services, Thang and Anh, 2002. In Lesotho, this would be feasible in the lowlands districts where villages are close together so is the distribution of health facilities where youth walk short distance from their homes.

#### **3.4.2 Age of a woman:**

Current age of women determines if increase in age have an influence on the use of contraceptives. It has been argued that adolescents aged 15-19 are likely to have lower prevalence of contraceptive use as most of them do not think they are at risk of falling pregnant. This is because of their limited knowledge about their sexual and reproductive changes and sometimes most of them are sexually inactive. Moreover, they use temporary methods such as condoms for protection on unintended pregnancy as they still want to enroll in schools and do not want to suffer negative consequences of dropping out of school as a result of parenting. They also have low levels of contraceptive use because of social

traditions that affect the acceptability of contraceptive use at these ages and economic barriers to access services (Agyei and Epema, 1992). On the other hand, those aged 20-24 years have the highest prevalence of contraceptives because they want to space or limit their childbearing. Gage (1998) argued that age is included because of sexual behavior change as well as decision-making about the behavior is influenced or vary with age.

#### **3.4.3 Education of women:**

Education is a very important factor influencing contraceptive use among sexually active young women and men. Young people who are still enrolled in school have the opportunity of gathering information regarding their reproductive health. Education exposes young people to a wider social network and gives them a chance to interact with their peers and medical personnel to discuss reproduction issues since they are much closer to health facilities within their premises/campuses. Ndyabangi, Kipp and Diesfeld (2004) state that the in school youth are able to access information and they have choices in life. Conversely, those who are non-students lack the opportunities because they are given little attention that leads to lack of self-confidence and exposes them to STIs and HIV/AIDS. Youth who are attending school take responsibility of their well being by choosing to use contraceptives mainly to prevent pregnancy so that it does not disrupt their education (Glasier, Gulmezoglu, Schmid, Moreno and Van Look, 2006). Ndyabangi, Kipp and Diesfeld (2004) argue that adolescents' who are in school delay engaging in sexual activities than those who are out-of-school. Educational attainment is measured by asking the question: 'What is the highest level of school has name attended' which contained four levels: a) no education, b) primary, c) secondary and d) higher education.

#### **3.4.4 Residential area (rural/urban)**

The variable was selected and coded as urban or rural. Urbanization and modernization have been associated with decline in fertility and increase in premarital sex as it has undermined traditions, norms and morals of many African societies (Makatjane, 2002; Nare, Katz and Tolley, 1997). They further indicate that rural areas are known to experience high fertility rates with low levels of contraceptive use than those in urban areas. The reason is that people in rural areas have to walk long distances to get to the health services or have to incur high costs where there are means of transports due to limited resources available compared to their counterparts in the urban areas (Tuoane, Madise and Diamond, 2004). Another reason may be

that urban couples have high levels of contraceptive use because of their preference of smaller families. This variable, place of residence was included in the analysis so as to establish the influence of contraceptives due to different regions.

#### **3.4.5 Wealth Index**

According to DHS (2004), wealth index was engaged to indicate the inequalities among households in relation to incomes, use of health services and health outcomes. The index was used as an indicator of the level of wealth in conjunction with expenditure and income measures. Moreover, it was constructed using household assets where information was collected on household ownership of the number of consumer items (i.e car, television, radio, sanitation facilities, type of material used for flooring). The report further states that each asset was assigned a score, then summed for each household. Individuals were ranked according to the total score of household in which they reside. Lastly, the ranks were divided into quintiles: poorest, middle and richest. Young women from the richest families have a higher likelihood of using contraceptives as they can access them at any cost.

### **3.5 Methods**

This study examines the influence of each independent variable on current use of modern method of contraception. These explanatory variables are age of a woman, condom use, place of residence, knowledge of modern methods, accessibility and availability of contraceptives and socio-economic variables such as education of a woman and her partner. Contraceptive use was evaluated by asking young adults questions: “Have you ever used any method of contraception?” and “Are you currently using any method to delay or avoid getting pregnant?” And analysis was constructed from the responses: 1) ever use, 2) currently using and 3) non-use. Secondly, to examine method choice, the question: “Which method are you currently using where women were allowed to indicate more than one method?” used. Responses were categorized as 1) temporary methods (i.e injectables, pill, IUD) and 2) non-use. Lastly, for condom use the question used was: “The last time of sexual intercourse, was a condom used?” From the responses, two categories were classified: 1) Yes 2) No. Bivariate analysis will be performed to explore the association between pairs of variables, that is how the factors identified above are associated with contraceptive use and also with condom use. Method use was categorized as modern use or non-use.



Multivariate logistic regression analysis was used to measure the mechanism of factors influencing contraceptive use. The enter method of logistic regression model was used to select variables. Three logistic regression models are presented in order to examine the effect of the selected variables. At first, variables were entered in order of importance (e.g age, current marital status and total children ever born). Secondly, the use of ordinary tests statistics was conservative to further reduce the model to variables significant at 0.05 levels. At these stage variables that are regarded as proxies for awareness and attitudes toward family planning programs such as type of place of residence and discussion of family planning with a partner were added. Finally, the model added educational level as the measure of ever use of contraceptive. Multivariate regression was used to estimate the change in dependent variable due to one-unit change of the independent variable assuming that the values of other independent variables are held constant (Norusis, 2003). In addition, multivariate logistic regression is also used to indicate the probability of young people using modern contraceptives with the purpose of delaying pregnancy. It examined whether contraception effect can be impeded by the predictor factors.

Chi-square tests on categorical data will be used to examine the association between contraceptive use and each of the independent variables by their social, economic and demographic background. For example, testing whether accessibility and availability of contraceptives measured by distance to the health centers (or number of health facilities that provide contraceptive methods per district) has an effect on teenagers' subsequent contraceptive behavior. Binary logistic regression is relevant due to the nature of the response to the dependent variable which is use of modern method of contraception. Logistic regression model is essential for the study because it is less restrictive as it does not necessarily require the linear relationship between the outcomes and the regressor variables. The impact of predictor variables is usually explained in terms of odds ratios. Odds ratios are defined as the ratio of the probability of an event occurring to the probability that it does not. The dependent variable can take the value of 1 with a probability of success  $\theta$  or the value of 0 with probability failure  $1 - \theta$ . Therefore, the logistic model can be in the form of log of the odds, that is the logit as follows:

$$\text{logit} [\theta(x)] = \log \left[ \frac{\theta(x)}{1 - \theta(x)} \right] = \alpha + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_i x_i$$

Where  $\beta_i$  is the vector of logistic regression parameters (regression coefficients) thus  $\beta_1$  is the increase in log-odds for a one unit increase in  $x_i$  with all the other  $x_i$ 's constant and  $\alpha$  is the intercept of the equation and it is a value of  $\theta$  when the value of all risk factors is zero. Each of the regression coefficients describes the size of the contribution of that risk factor. These are usually the estimate by maximum likelihood methods assuming the product binomial distribution for the binary responses. When  $b$  has to move from 0 to 1 then there is an increase in the log-odds of the dependent variable and also there is an increase on the corresponding odds ratios. For example, the binary variable contraceptive use at last sexual intercourse (1=yes, 2=no) is predicted from place of residence (1=urban, 2=rural) and age (continuous variable). If the odds ratio is 1.7 for place of residence (1=urban, 2=rural) and dependent variable is contraceptive use, then the odds of adolescent living in rural areas is 1.7 times the odds of adolescent living in urban areas for not using contraceptives. Explanatory variables were fitted according to their importance to contraceptives by incorporating demographic, socioeconomic and health resource supply. All analysis was conducted using SPSS computer software 15.0 version.

Table 3.1 presents the total number and percentage distribution of young women by selected number of socio-demographic characteristics with contraception. The table depicts a higher percentage (54.7 percent) of the sample for women aged 15-19 years as opposed to 45.3 percent of women aged 20-24 years. Furthermore, 75 percent of the sample size was from the rural areas while only 25 percent was from the urban areas. On the marital status, a large percentage of young women were never married (62 percent) then 34.7 percent who were married and the last were young women who were previously married (1.5 percent). Majority of the women (94.5 percent) reported to have knowledge of contraceptive methods. However, only 17.7 percent of women were current users of modern methods of contraceptives while 82.3 percent had not used any method. The same pattern was observed for condom use with a large number (75.6 percent) of young women who were non-users of condoms. Most young women reported government health centers as their main source of family planning methods compared to other sources of family planning.

**Table 3.1: Sample Distribution of women by selected number of socio-demographic characteristics associated with contraception.**

<b>Individual characteristics</b>	<b>Percentages</b>	<b>Number of women</b>
<b>Age Group</b>		
15-19	54.7	1761
20-24	45.3	1456
<b>Education</b>		
Primary	59.5	1913
Secondary+	40.5	1304
<b>Place of Residence</b>		
Urban	25	805
Rural	75	2412
<b>Religion</b>		
Roman Catholic	45.1	1452
Lesotho Evangelical Church	19.6	628
Other Christian	35.3	1137
<b>Marital Status</b>		
Never married	62	1996
Married/Living together	34.7	1117
Previously married	1.5	104
<b>Other characteristics</b>		
<b>Knowledge of contraceptive methods</b>		
Modern methods	94.5	3039
No method	5.5	178
<b>Ever use of contraceptives</b>		
Modern methods	36.9	1188
Never used	63	2029
<b>Current use of contraceptives</b>		
Modern methods	17.7	589
No method	82.3	2628
<b>Condom Use</b>		
Use	24.4	500
Non-use	75.6	2717
<b>Discussion of FP with partner</b>		
Never	33.8	375
Once or twice	30.2	335
More often	35.9	398
<b>Source of Family Planning</b>		
Government hospital	22.1	124
Government health centers	30.7	172
Private hospital, clinic	14.5	81
Other Private Medical	32.6	183

Source: LDHS, 2004.

### **3.7 Limitations of the study**

DHS as a quantitative study encounter drawbacks to its accuracy of data. Due to the fact that it uses a designed questionnaire with structured responses, respondents can give answers they think satisfy the interviewer. Because the study interest is focused on the adolescents, sensitive questions such as sexual behaviour can lead to underreporting of their behaviour. This is due to the concerns of social disapproval by society as in Lesotho sexual related issues are still a taboo that may not be discussed with young people (Gupta, 2000). Moreover, the limitation to accurate information is because most of the interviewers are older than the respondents, and adolescents especially women do not want their sexual experience to be known by the public even though they have been assured of confidentiality of the information they provide (Gage-Brandon and Meekers, 1993). In contrast, men can provide incorrect information in order to show their masculinity and knowledge about contraceptives. For example, men reporting more consistent contraceptive use, especially condom use than females when, in fact, some were not. Other common problems are omissions or misreporting of events that are done deliberately which can bias the results and have impact on the data analysis. Data collection using personal interviews seems to create reporting errors and that makes sexual behaviour difficult to be measured accurately as it is the only source of information that can be used (Marindo, Pearson and Casterline, 2003). The use of peers as interviewers might be the solution to correct information as adolescents will feel comfortable to talk to people of their age and experience the same problems. This will enable family planning programs to identify the proportion of adolescents who are in need of their services.

### **3.8 Summary**

This study employs secondary data from the 2004 LDHS with the target population being young people aged 15-24 years and the sample size is 3217. The variables of interest are contraceptive use, method choice and condom use at last sexual intercourse among young people. Explanatory variables influencing contraceptive use are: age of a woman, condom use, place of residence, knowledge of modern methods, accessibility and availability of contraceptives and socio-economic variables such as education of a woman and her partner. Binary and multivariate logistic regressions are the models used for analysis. Odds ratios are presented to give estimates of the effect of predictor variables to the dependent variable.

## **CHAPTER FOUR**

### **FINDINGS AND DISCUSSIONS**

#### **4.1 Introduction**

The chapter presents the analysis of the effect of selected independent variables on contraceptive use among young people in Lesotho. Information on socio-economic and demographic characteristics was included in the analysis based on their hypothesized relationship with contraceptive prevalence to be positive. Accessibility and availability of contraceptives by young people is very important. Access by districts and availability of health facilities is expected to have a strong effect in Lesotho. Moreover, low levels of knowledge regarding sources of modern methods may indicate limited access, availability of contraceptives and related services and need a special attention. The presentation is divided into four parts: patterns of contraceptive use, knowledge and attitudes towards contraception, determinants of contraceptive use and patterns of condom use among young women aged 15-24 years. The discussion for each sub-section is included after the presentation of data. There are several types of methods of contraception but for the purpose of this report only modern methods will be considered because traditional methods are regarded as obstacles for many adolescents (Brindis, Starbuck-Morales, Wolfe and McCarter, 1994).

##### **4.1.1 Sexual activity of women aged 15-24 years**

Table 4.1 below shows that 32.9 percent of women who have had sexual intercourse were from the urban areas compared to 67.1 percent from the rural areas. However, this is not a normal pattern as other researchers found urbanite women to have a higher likelihood of using contraceptives than those from rural areas. As literature has shown, rural areas are disadvantaged because most resources are located in the urban areas. A higher percentage, 71.1 percent who have experienced sexual intercourse were observed among women aged 20-24 years than those aged 15-19 with 28.9 percent. Meschke, Bartholomae and Zentall (2000) showed that sexual activity increases with age whereby young people aged 18-21 are more sexually experienced than those aged 15 years. About 52.2 percent of women who had sexual intercourse had attained secondary education compared with 47.9 percent of those who had primary education. As expected, differential by marital status indicates that 54.4 percent of those having had sexual intercourse were among the married or living together with partner

while 45.6 were from the never married young people. The results indicate that those who have never married are less likely to be sexually active. However, the total for marital status does not add up to the total number of sexually active adolescents because of previously married category that was insignificant.

**Table 4.1: Percentage distribution of women aged 15-24 years who had sexual intercourse by selected characteristics, Lesotho 2004.**

Characteristic	Percent	Number of women
<b>Type of place of residence</b>		
Urban	32.9	805
Rural	67.3	2412
<b>Age</b>		
15-19	28.9	1761
20-24	71.1	1456
<b>Education</b>		
Primary	47.9	1913
Secondary	52.2	1304
<b>Marital status</b>		
Never married	45.6	1996
Married/Living together	54.4	1117

Source: LDHS, 2004.

±:N add to slightly less than the total because of missing data.

\*Significant: \*\* $p \leq 0.01$ , \*\*\* $p \leq 0.001$

## 4.2 Patterns of contraceptive use

Contraceptive use has been classified as the most effective proximate determinants of fertility by many scholars (DeGraff, 1991). Most young people's responses indicate a high knowledge of contraceptives but this does not always imply contraceptive use (Oni, Prinsloo, Nortjie and Joubert, 2005; Agyei and Epema, 1992). Among factors of interest in determining the prevalence of contraception are; knowledge of contraceptives, ever and current use of contraceptives and knowledge of source of contraceptives. Ever use indicate that contraceptives have been tried. Young people, 15-24 years interviewed in 2004 LDHS who responded to have heard of contraceptive methods were further asked if they have ever used a method mentioned. Current method used may show the success of family planning programs in their promotion of modern methods in a community. Brindis, Starbuck-Morales, Wolfe and McCarter (1994) asserts that an increase in contraceptive use is observed among school going students as they receive health education and counseling services from family planning

centre's within their compounds. Table 4.2 below illustrates sexually active young people aged 15-24 years who reported to have used contraceptives at the time of the interview.

**Table 4.2: Percentage of sexually active women aged 15-24 years by use of contraceptive by type of method, Lesotho 2004.**

Contraceptive methods	Prevalence	
	Ever use (671)	Current use (242)
<b>Modern methods</b>		
Pills	25.5***	7.3***
IUD	3.1*	0.9***
Injectables	31.6***	14.8***
Male condoms	44.4***	10.4***
Female condom	50.0	0.1***
Female sterilization	2.0**	0.9***
<b>Traditional methods</b>		
Withdrawal	24.2*	1.0***
Lactational amenorrhea	12.8***	0
Local traditional methods	6.0	0.6***

Source: LDHS, 2004.

\*Significant: \* $p \leq 0.05$ , \*\* $p \leq 0.01$ , \*\*\* $p \leq 0.001$

Sexually active women were women who have engaged in sexual relation and were at risk of conception in the last four weeks prior to the interview. About 671 (20.9 percent) of the total number of adolescents aged 15-24 were sexually active during the last four weeks prior to the interview. However, the totals in table 4.2 above for current users do not add up to this total because a large number, 429 young women, who responded as sexually active in the last four weeks were not currently using contraceptives. Although respondents have shown knowledge of condoms, a small percentage of the total sexually active young women had used condoms at the time of the interviews (44.4 percent). Injectables and the pill followed with 31.6 and 25.5 percent respectively. About 24.2 percent of women had ever used withdrawal. It was followed by 12.8 percent of those who ever used lactational amenorrhea. However, young women seem not currently using the method to prevent pregnancy, thus they are no longer breastfeeding for a long period. Local traditional methods were the least (0.6 percent) to be currently used by adolescents.

### 4.3 Knowledge and attitude towards contraception

Knowledge of contraceptives is important because of its influence on changes in fertility and reproduction as it shows awareness on controlling fertility within a society. More educated people, living in urban areas where they are closer to health facilities and more exposed to media (radio and television) are more knowledgeable about contraceptives (Parr, 2002). Kincaid (2000) asserts that women who know about family planning and have experienced or have ever used the methods find it easier and are confident with the method they are using. Information on knowledge of contraceptives was gathered from two questions. During the 2004 Demographic and Health Survey, respondents were asked to indicate knowledge of methods in this question, "Which ways or methods have you heard about that a couple can use to delay or avoid a pregnancy?" For the methods that the respondent did not mention, the next question asked was "Have you ever heard of (method) where the interviewer had to name and describe the method and note if recognized. Furthermore, women were asked "Have you ever used or tried in any way to delay or avoid getting pregnant where a small percentage had ever used contraceptives. In their study conducted in rural South African high schools, Oni, Prinsloo, Nortjie and Joubert (2005) found that a high percentage of sexually active students' did not use contraceptives, 75.2 percent males and 61.5 percent females. Table 4.3 below presents percentage distribution of women by knowledge of contraceptive methods. Note that this was a multiple response question meaning that one respondent was allowed to mention more than one method of contraception.

**Table 4.3: Percentage of women aged 15-24 years by knowledge of contraceptive methods, Lesotho 2004.**

<b>Contraceptive methods</b>	<b>Percentages</b>
<b>Modern methods</b>	
Pills	73.7
IUD	43.8
Injectables	75.7
Male condoms	91.6
Female condom	35.8
Emergency contraception	21.3
Other methods	11.5
<b>Traditional methods</b>	
Withdrawal	64.7
Periodic Abstinence	31.1
Other methods	22.6
<b>N</b>	<b>3039</b>

Source: LDHS, 2004.



Male condoms were the predominantly known method of contraception (91.6 percent) among young women. As indicated in the previous paragraph, this was a multiple response question whereby respondents were allowed to mention as many methods that they know. The second commonly known method is the injectables, 75.7 percent followed by the pills with 73.7 percent. Young women also reported to be knowledgeable of intrauterine device, IUD which constituted 43.8 percent. Female condom also was recognized by young women (35.8 percent). The results reveal that reproductive health programs targeting the youth promote condoms more than other methods. This is due to its multiple protections against pregnancy, STIs including HIV infections. UNFPA (2005) indicates that condom availability will empower women to smooth the progress of cooperation with their partners on use of condoms.

Condoms are universally known by young people because of their widespread promotion through different types of media, mainly radio, television and posters across all the regions of the country. Furthermore, they are also placed everywhere in public places where adolescent can have them at any time. They are even placed at the bathrooms where one can take privately without others recognition which indicates a wide distribution. Maharaj and Cleland (2006) assert that college students in Durban preferred condoms because they could get them from the counter, relieving them from going to health facilities. The promotion of condoms is further emphasized by HIV/AIDS facilitators who hold workshops and campaigns to demonstrate how to use condoms correctly. Youth-friendly and communicating with parents' campaigns about reproductive health matters also increase their contraceptive knowledge. This high knowledge shows the progress of promotion programs and that it has reached the target population reproductive health well therefore giving them strength to continue.

The least known method is the emergency contraception (21.3 percent). The Ministry of Health and Social Welfare (MOSHW) in Lesotho take full responsibility in the promotion of these family planning programs. A large number of young people indicated knowledge of withdrawal (64.7 percent) and periodic abstinence constituted 31.1 percent. Traditional methods are mostly known by young people in the rural areas due to lack of access to health facilities in terms of location and transport. Long distances to reach the health facilities are the barrier for young people to use modern methods resulting to limited knowledge about them.

#### **4.3.1 Perception of methods**

Adolescents' reasons for not using contraceptives were amongst others fear of side effects, lack of access and infrequent sexual intercourse. Researchers showed that young people's perceptions on the methods were that with injectables, women realized an adverse effect of gaining weight (Indian Medical Ethics, 2005). In addition, infrequent and unpredictable menstrual bleeding reported as disturbing because they are not sure whether they are pregnant. As for the pills, there is a high risk of unplanned pregnancy if one skips one day without taking them. Moreover, women feel ashamed to have the pills in the presence of other people especially their parents and partners. The common responses were that condoms reduce sexual pleasure; they suggest infidelity of a partner and can burst into the vagina during sexual intercourse (Okonkwo, Fatusi and Ilike, 2005). The results from the study conducted by Aziken, Okanta and Ande, 2003 accentuate that lack of knowledge about emergency contraception among undergraduates' students in Nigeria made them not to trust its effectiveness of giving young people a second chance of preventing unplanned pregnancy.

Young people's acceptability of family planning and their perceptions about specific contraceptive methods have repercussion on their use. Rosental and Shannon (1997) noted perceptions of clients on contraceptive use was measured by quality of care, clients satisfaction and access to health facilities. Health centers that offers different types of birth control methods are able to attract more clients as there is no single method that can satisfy everybody, which result in a successful family planning programs. Clients-provider communication and good care are desired to motivate young people to practice contraceptives. In this study perceptions of methods are measured by quality of care from health facilities, that is whether they get enough information about contraception. Respondents who have ever used a method were asked a question whether when they visited the health facilities they were told about other methods of contraceptives. Also, to give reasons why are they not using any family planning method to prevent a pregnancy yet they said they do not want to have a child very soon. Note that this was a multiple response question meaning that one respondent was allowed to give more than one reason of not using method of contraception.

**Table 4.4: Perceptions of adolescents' aged 15-24 years on contraceptive methods.**

Characteristic	Percentage
<b>Main reasons not to use a method</b>	
Not married	28.0
Subfecund, infecund	12.8
Want more children	10.1
Respondent oppose	14.0
Fear side effects	35.1
<b>Told about side effects by health or FP worker</b>	
No	80.2
Yes	19.8
<b>Told about other FP methods by health or FP worker</b>	
No	72.3
Yes	27.7
<b>N</b>	<b>560</b>

Source: LDHS, 2004.

The results in table 4.4 shows that 35.1 percent of women reported fear of side effects as their main reason not to use a method of contraception. This shows lack of information by providers about advantages and disadvantages of different methods of contraception. It is confirmed by a lower percentage of respondents (19.8 percent) who indicated to have been told about side effects by a health or family planning worker compared to 80.2 percent of those who responded not to have been told about side effects of methods of contraception. Moreover, many respondents 72.3 percent reported that they were not told about other family planning methods by health or family planning workers. This indicates that young people are not well accommodated by the service providers which lead to dissatisfaction and lack of use the methods.

#### **4.4 Determinants of contraceptive use**

The results present the socio-demographic and economic determinants of contraceptive use among young people. The bivariate analysis used cross-tabulations to show associations.

##### **4.4.1 Socio-demographic determinants**

Age of young people has a robust influence in contraceptive use. Table 4.4 below shows a small difference between young people who have ever used and current users of contraceptive. Contraceptive use increases with age whereby only 28.9 percent of current

contraceptive users are among adolescents' aged 15-19 years while the rest, 71.1 percent were in the age group 20-24 years. The same applies to those who ever used a method with 30.6 percent of ever use of contraceptives were among the 15-19 year-olds to 69.4 percent which is in ages 20-24 years and this may be due to their sexual exposure and sexual debut. Sathar, Jain, RamaRao, Haque and Kim (2005) indicate that there is low contraceptive use at the start of reproductive ages (15-19) that may be explained by providers attitudes towards socio-cultural context regarding adolescents sexuality onset. Furthermore, lack of information about family planning at these ages (15-19) and communication concerning sexual issues is not convenient.

**Table 4.5: Percentage of women aged 15-24 years who has ever practice and current users of contraception by socio-demographic characteristics, Lesotho 2004.**

<b>Characteristic</b>	<b>Ever use</b>	<b>Current use</b>
<b>Age***</b>		
15-19	30.6	28.9
20-24	69.4	71.1
<b>Highest educational level***</b>		
No education	1.0	0.4
Primary	50.9	47.5
Secondary	47.1	51.5
Higher	1.0	0.7
<b>Current marital status***</b>		
Never married	46.8	45.6
Married/Living together	53.2	54.4
<b>Total children ever born***</b>		
None	37.3	34.5
One	41.1	46.1
Two	21.6	19.4
<b>N</b>	<b>1188</b>	<b>571</b>
<b>Chi-square</b>	<b>0.000(2)</b>	<b>0.000(2)</b>

Source: LDHS, 2004.

\*Significant: \*\*p≤0.01, \*\*\*p≤0.001

The table further shows that 41.1 percent of women who ever used contraceptives had one child, followed by 37.3 percent of women who were childless. The rest were women who had ever used contraceptives and had two children (21.6 percent). Furthermore, the results show a similar patterns for current use from 34.5 percent of women who have not given birth to children to 19.4 percent of women who have given birth to two children. The table also shows that 53.2 percent of those who ever use contraceptives were among the married/living

together compared to never married women with 46.8 percent. Moreover, 54.4 percent of current contraceptive users were married/living together compared with 45.6 percent of never married young women. These results are consistent with Tuoane, Diamond and Madise, 1998 study where married or living with a partner among young adults had the higher likelihood of using contraceptives.

#### **4.4.2 Socio-economic determinants**

There is a relationship between contraceptive use and education of young people. Current users are likely to have primary (47.5 percent) or secondary (51.5 percent) education rather than no education (0.4 percent) or higher (0.7 percent). The differentials could be that the youth who have higher education are those in older ages, whereas those with primary levels of education are at the younger ages. It was observed that young people with higher education had a low percentage, 0.7 and 1.0 percent of current and ever use of contraceptives which is due to small sample size. Privileged educated women are able to gain power to adopt western methods of family planning and act as a source of information and circulate it to others. With effective contraception, women at younger ages are better able to study without the interruption of unplanned childbearing, thus education makes young people make informed choices in their lives. Most of these young people are eager to practice their professions in the real world which means, getting remunerative employment and enjoy their earnings first before they can commit themselves with children hence the high demand of contraceptives.

Contraceptive use is highly influenced by the wealth of the household of young people. According to LDHS (2004), wealth index was included to indicate the inequalities among households in relation to incomes, use of health services and health outcomes. The index was used as an indicator of the level of wealth in conjunction with expenditure and income measures. Moreover, it was constructed using household assets whereby information was collected on household ownership of the number of consumer items. Assets were assigned scores and summed up to give them ranks according to their totals. Lastly, the ranks were divided into quintiles from poorest, middle and richest. The results in table 4.5 shows an increasing pattern of contraceptive use in respect to wellbeing. A lower percentage of both ever (19.7 percent) and current (19.4 percent) contraceptive use is experienced by those who were from the middle households. A higher level of ever contraceptive use is for those from the richest families, 48.0 percent, followed by those who are from the poorest families with 32.3 percent. A similar situation is encountered for the current use of contraception whereby

51.7 percent of young people were from the richest families and 28.9 percent were from the poorest families. Hogan, Astone and Kitanawa (1985) support the results by indicating that young adults who are sexually active from high socio-economic status had the highest likelihood of using contraceptives than those from the depressed poor and disrupted families. In addition, poverty plays a vital role in hindring to access contraceptives among the poor (Campell, Ndola and Malcolm; 2007).

**Table 4.6: Percentage of women aged 15-24 years who has ever practice and current users of contraception by selected characteristics, Lesotho 2004.**

<b>Characteristic</b>	<b>Ever use</b>	<b>Current use</b>
<b>Discussed FP with partner***</b>		
Never	20.8	12.7
Once or twice	32.2	29.9
More often	47.0	57.4
<b>Religion***</b>		
Roman Catholic Church	44.1	48.1
Lesotho Evangelical Church	21.3	23.2
Methodist	1.7	1.4
Anglican	9.5	10.7
Other Christian	23.4	23.0
<b>Wealth Index***</b>		
Poorest	32.3	28.9
Middle	19.7	19.4
Richest	48.0	51.7
<b>Type of place of residence***</b>		
Urban	28.6	32.9
Rural	71.4	67.1
<b>District***</b>		
Butha-Buthe	11.6	13.5
Leribe	12.9	12.4
Berea	10.0	8.2
Maseru	15.9	15.1
Mafeteng	9.0	11.0
Mohales' Nek	12.0	11.9
Quthing	10.2	9.3
Qachas' Nek	7.7	10.0
Mokhotlong	5.1	4.0
Thaba-Tseka	5.7	4.6
<b>N</b>	<b>1188</b>	<b>571</b>
<b>Chi-square</b>	<b>0.000(4)</b>	<b>0.000(4)</b>

Source: LDHS, 2004.

\*Significant: \*\*p≤0.01, \*\*\*p≤0.001

#### **4.4.3 Differentials by Place of Residence**

The type of place of residence is a pertinent indicator to determine the level of contraceptive use among young people. This can be emphasised by the fact known that 'in most developing countries, provision of better socio-economic amenities like good health services infrastructure are always in favour of the urban areas at the expense of rural areas' (Bulane, 1996:14). Therefore, the results from table 4.5 are surprising as they show a high percentage of current use of contraceptive (67.1 percent) in the rural areas and a low percentage (32.9 percent) in the urban areas. Moreover, 28.6 percent of urban young women have ever used contraceptives compared to 71.1 percent of those in the rural areas. This may be explained by the number of respondents (848 from rural areas to 340 from urban areas) or the fact that majority of women in the rural areas may use injectables as they get them once in three months. This is not consistent with Moteetee, 2005 showing that other barriers for rural adolescents to increase their level of contraceptives is the shortage of nurses and doctors in these areas. This shortage leads to referral to other health facilities/hospitals, sometimes because of the need of a specialist like a doctor to insert an IUD which means to incur costs which is another problem, Moteetee adds. Bhargava, Chowdhury and Singh (2005) state that rural areas suffer because even with NGOs efforts to improve health services, they are mitigated by logistical difficulties in allocating technological advanced equipments to these areas. A large part of Lesotho's terrain is mountaineous which impedes access to services for young people.

Districts are significant as a measure of accessibility and availability of contraceptive use as well as method choice. The variable determine the effect of health facilities on the decision of using contraceptives method by young people. It has been documented that the likelihood of the increase in contraceptive use is highly determined by the presence of a health facility in a community. The prevalence of contraceptive use is very high in communities where they are provided by the LPPA and hospitals which are found in Maseru the capital town (Tuoane, Diamond and Madise, 2004). Table 4.5 above shows higher likelihood of ever (from 9.0 percent to 15.9 percent) and current (from 8.2 percent to 15.1 percent) contraceptive use in the districts that are largely urbanized. As expected, Maseru had the highest ever use (15.9 percent) and 15.1 percent of current use of contraceptives because of its advantages to accessibility of administrative resources. Districts which are classified as mountainous, showed a high percentage of ever use, 12.0 percent were from Maseru's Hoek and 11.9 percent of current contraceptive users. Other districts experienced lower levels of ever use,

whereby 10.2 percent of ever use of contraceptive were among adolescent from Quthing district, Qachas' Nek (7.7 percent), Thaba-Tseka (5.7 percent). Adolescents with the least percentage of ever use of contraceptives, 5.1 percent were from Mokhotlong district. For current use of contraceptives, 11.9 were from Mohale's Hoek, Quthing had 9.3 percent, Qachas' Nek 10.0 percent, Thaba-Tseka with 4.6 percent and 4.0 percent from Mokhotlong.

This may be because health providers are still attached to tradition where sexual relations and childbearing are considered to be for married couples only despite the Adolescent Reproductive Health (ADHR) that have been opened in hospitals. The study conducted by Tuoane, Diamond and Madise (2004) state that teenagers were not offered pills and IUD because they were not married and have not had children. The provider's did not want to be held responsible if teenagers become sterile. Moreover, they were told by providers to change to other methods they do not want to use. Sometimes this is because they were out of stock of some family planning methods. This led to incorrect and inconsistency of methods used because of dissatisfaction of the clients and exposes them to the risk of unplanned pregnancies and diseases.

#### **4.4.4 Other factors determining contraceptive use among young people**

Table 4.5 further indicates that adolescents' with the lowest ever use of modern contraceptives, 20.8 percent was observed to those who do not discuss use of contraceptives with their partners compared to 47.0 percent of ever use to those who discusses contraceptive use more often. Manlove Ryan and Frenzetta (2003) state that partners type of relationship have influence on the use of contraceptives where those in 'steady relationships' increases use of modern methods. The same pattern was also observed to current use of contraceptives with 12.7 percent to 57.4 percent respectively. Casterline, Sathar and Haque (2001) have shown that nonuse of contraceptives has been determined by inexperience and poor communication among partners. Most of these youth choose hormonal methods because their partners will not know that they are using any family planning method to prevent unplanned pregnancies. However, as young people report discussing contraceptives use more often with their partners, contraceptive use increases. Couples who often communicate about family planning have the likelihood of increase in contraceptive use the stronger the relationship becomes (FHI, 1998). Young men agree on their partners' contraceptive use because they believe that it benefits their health and improves quality of life.



Religious affiliation have a huge impact and result to low levels of contraceptive use. Mberu (2008) pointed that catholics are distinguished from other denominations because of their conservative views on sexual behaviour and contraceptive use. However, the results show that 44.1 percent of ever use of contraceptives were among adolescents' from the Roman Catholic Church in Lesotho. It was followed by 23.4 percent of ever use of contraceptives from Other christians adolescents', then LEC adolescents' with 21.3 percent and Anglicans had 9.5 percent. The least percentage of ever use of contraceptives was found among young people who belong to the Methodist church (1.7 percent). Most of these denominations regard young people who use contraceptives to be promiscuous, abstinence till marriage is their main motto. Studer and Thornton (1987) posit that the Protestant and Catholic churches prohibited birth controls among young people as they first condemn sexual relation outside marriage. In contrast, recent studies by Goldscheider and Mosher (1991) indicate that there has been a change in religion and religious commitments as most religious affiliations have shown more tolerance on adolescents sexual activities and easy access to contraceptives. The most popular birth controls used by many never-married catholics are pills, diaphragm and condoms while protestants use condoms in the United States, Goldscheider and Mosher, 1991.

#### **4.4.5 Multivariate analysis on contraceptive use**

Further analysis on factors influencing contraceptive use are been presented. As the follow-up of the chi-square test which determines the significance between the dependent variables and the independent variables, the use of logistic regression model is essential in order to measure the effect of some selected socio-demographic and economic characteristics on contraceptive use among the youth. Logistic regression is chosen due to its ability to predict the likelihood that the respondent will use family planning methods to prevent a pregnancy and controlling for other factors. It also gives the net impact of each independent variable on the dependent variable. Dummy variables were created for categorical variables whereby reference category was selected on each socio-demographic and economic characteristics. The reference category for age groups will be age group 20-24. For marital status, married/living together will be the reference category while the reference category for educational level will be higher education. Total children ever born reference category will be two children whereas type of place of residence would be rural areas.

The analysis was conducted using several nested models (at most three models were used) to test the validity of each variable to the dependent variable. It was of interest for this analysis first to try to single out the net impact and ascertain the independent effect of each predictor variable on contraceptive use. The aim was to check whether introducing other control variables to the model will improve their effect to the use of contraceptives. This was done by entering each predictor variable alone with contraceptive use with the aim of testing its strength in influencing contraception and were independently significant.

The second step was whereby socio-demographic control variables were entered together in order of importance to check whether there will be any change in their strength of relationship to contraception. Then more variables were added to the model. Individual background characteristics that were selected to have robust effect on contraceptive use are: age, total children ever born, marital status, type of place of residence, discussion of family planning with partner, educational level and wealth. Results are presented as odds ratios. Table 4.7 below introduces socio-demographic control variables with respect to current contraceptive use in different models. Current contraceptive use was chosen for analysis as it will show the success of family planning programs in their promotion of modern methods in a community.

The results show that age play a vital role in influencing contraceptive use as it shows an increasing effect through the models though they are not statistically significant. This is shown by the odds ratios in table 4.7 where those in the age-group 15-19 years are about half less likely to use contraceptive than those in age-group 20-24 years. Women who have never married depicts a lesser odds (odds ratio=0.280 and 0.420) of using contraceptives compared to those who are married or living together. Both age and marital status lost their strengths as other control variables were added to the model. However, marital status was removed from model 2 because of a high number of missing values encountered in the model (N=2202).

Type of place of residence was introduced in model 2 to test whether the strength of contraceptive use is affected by variations in regions of residence. The result reveal unexpected results whereby women who reside in urban areas are less than half likely to use contraceptives than those who reside in rural areas. Most of the control variables seem to have lost strength when including this variable, type of place of residence.

Discussion of family planning with a partner was also added to the model to check whether there is any association. This variable is important because if young people are able to communicate about family planning methods it will enable them especially women to negotiate safer sex as it has been always a taboo for them as it was a men thing. Moreover, they will gather more information to prevent unwanted pregnancies and other infections. Young people who responded to never discussed family planning with their partners show a lesser level of contraceptive use (odds ratio=0.194) to the reference category. The same pattern is also observed for those who indicated to have discussed once or twice (odds ratio=0.322) although they show a statistical significance to contraception. UNFPA (2005) showed that encouraging communication by sharing responsibility for reproductive health (sex and family planning) would be an effective strategy to mobilize communities to prevent STIs including HIV and unplanned teenage pregnancy.

**Table 4.7: Odds ratios of current contraceptive use by selected characteristics**

Characteristic	Model 1	Model 2	Model 3
	Odds ratio	Odds ratio	Odds ratio
<b>Age</b>			
15-19	0.934	0.517	0.543
20-24 (ref)	-	-	-
<b>Marital status</b>			
Never married	0.420*		
Married/Living together (ref)	-	-	-
<b>Total children ever born</b>			
None	0.910	0.171	0.138
One	1.134	1.190***	1.119***
Two (ref)	-	-	-
<b>Discussed FP with a partner</b>			
Never		0.194**	0.186
Once or twice		0.322**	0.335
More often (ref)		-	-
<b>Type of place of residence</b>			
Urban		0.462*	0.357
Rural (ref)		-	-
<b>Highest educational level</b>			
No education			0.000
Primary			0.634
Secondary (ref)			-
<b>Wealth Index</b>			
Poorest			0.755
Middle			0.550
Richest (ref)			
<b>N</b>	<b>3217</b>	<b>3217</b>	<b>3217</b>
log likelihood	421.541	419.323	415.5

Source: LDHS, 2004.

\*Significant: \*\* $p \leq 0.01$ , \*\*\* $p \leq 0.001$ , ref= reference category

In model 3 is where two other predictor variables, educational attainment and wealth have been added to the previous models with the same aim of checking whether there will be any effect on the strength of other control variables to contraceptive use. Level of education is important in determining contraceptive use, meaning education enable women to obtain and use family planning methods. The odds ratio of women with no education shows that they are the least to use contraceptives compared to other educational levels. Those with primary education are slightly more than half (odds ratio=0.634) times less likely to use contraceptive to those in the reference category, however not statistically significant.

Adolescents from the poorest families are less likely (odds ratio=0.755) to use contraceptives with those from the richest families. Young people from the middle families are about half (odds=0.550) of those from the richest families to use contraceptives.

#### **4.5 Patterns of condom use among young women, 15-24 years.**

Condoms use is analysed independently because it has been proven to have multiple protection for young people and are user-friendly over other methods of contraceptives. Mberu (2008) asserts that condoms plays a critical role in preventing unwanted pregnancies and HIV infections among sexually active youth while used consistently and correctly as it has been linked with 90-95% effectiveness. Meschke, Bartholomae and Zental (2000) state that young people who are using other methods are only preventing pregnancy while still at risk of contracting STIs and HIV infection. Furthermore, those at the ages of 15-17 years encounter a higher risk as they tend to have multiple higher risk partners due to their stage where they experience many challenges at the same time. Meschke, Bartholomae and Zental add.

##### **4.5.1 Socio-demographic determinants**

Condom use patterns are an important tool to assess the national goals for sexual behavioural change and prevention of HIV infections among young people (Abdullah, Fielding, Hedley, Ebrahim and Luk, 2002). Abma and Macgill (2007) and Borgoni and Billari (2003) state that condom use at first sexual intercourse is the propensity to subsequent use of consistently and regularly in the future. It is also important because young people do not need any consent to use them or have to face the arrogance of health providers at the health facilities.

**Table 4.8: Percentage of women aged 15-24 years who used condom at last sexual intercourse by selected characteristics.**

<b>Characteristic</b>	<b>Condom use at last intercourse</b>	<b>Number of women</b>
<b>Type of place of residence***</b>		
Urban	61.7	378
Rural	38.3	1296
<b>Age*</b>		
15-19	59.3	614
20-24	40.7	1060
<b>Highest educational level***</b>		
Primary	38.8	3018
Secondary	61.2	636
<b>Current marital status***(+)</b>		
Never married	75.6	570
Married/Living together	24.4	1104
<b>Total children ever born***</b>		
None	64.1	702
One	25.4	650
Two	10.5	322
<b>Discussed FP with partner***(+)</b>		
Never	16.5	337
Once or twice	37.1	313
More often	46.4	365
<b>Religion**(+) </b>		
Roman Catholic Church	45.7	754
Lesotho Evangelical Church	22.7	322
Methodist	1.2	30
Anglican	10.3	146
Other Christian	20.1	429
<b>Heard FP on radio***</b>		
No	68.2	1266
Yes	31.8	408
<b>Relationship to partner***(+)</b>		
Spouse, cohabiting partner	25.6	1040
Girlfriend, fiancée	74.4	631
Chi-square	0.000(3)	

Source: LDHS, 2004.

+:N add to slightly less than the total because of a small number of respondents.

\*Significant: \*\*p≤0.01, \*\*\*p≤0.001

Table 4.8 above shows that adolescents' aged 15-19 have a higher likelihood (59.3 percent) of using condoms than those aged 20-24 with 40.7 percent. This is consistent with other researches that indicated high condom use among 15-19 year-olds than those aged 20-24 years (Maharaj and Cleland, 2006). Meekers and Klein (2002) state that as age increases young women turn to be in steady relationships hence decrease in condom use. Marital status is associated with condom use where 75.6 percent of women who had used condoms at their last sexual intercourse were not married compared to 24.4 percent of married/living together. This may be because, those who are not married are still expecting to have children in the future as a result then they would prefer temporary methods. Tuoane, Madise and Diamond (1998) asserts that never married women have high motivation to prevent births as having premarital birth would reduce their chances of continuing their education. This concurs with the hypothesis that never married women are more likely to use condoms than those who are married/living together.

There is a relationship between condoms use and children ever born. High levels of condom use at last sexual intercourse is reflected to women with no children, 64.1 percent and then decline as the number of children increases, 25.4 percent of condom use at last sexual intercourse for those with two children. The results show that 74.4 percent of young people use condoms with their girlfriend/fiancée than with their spouses/cohabiting partners, 25.6 percent. This is consistent with the results from Manlove, Ryan and Franzetta (2003) study where they indicated that women from one city responded to using contraceptives with other relationships than with their regular partners of long term (considered more than one year in a relationship). This is because as the relationship is established, couples have increased trust in each other and the relationship is regarded as permanent and therefore less likely to use contraceptives.

When asked why they used condoms in their last sexual intercourse, the majority responded that they used condoms as to prevent both pregnancy and STIs including HIV/AIDS. The second most response was for those whom their main reason was to prevent pregnancy only in table 4.9 below. Adlh and Alexander (1999) found that youth in Ghana used condoms at their last sexual intercourse because of the support or a partner insisted on using a condom. Moreover, others state that it was because of their self-belief that they had to use condoms after establishing that they were susceptible to HIV infection and that there were low barriers to access and use condoms, Adlh and Alexander add.

**Table 4.9: Percentage distribution of young people aged 15-24 years by reasons used condoms at their last intercourse**

Characteristic	Percentage
<b>Reasons used a condom</b>	
Prevent STD/HIV	13.9
Prevent pregnancy	35.2
Prevent STD/HIV and pregnancy	46.9
Did not trust partner	0.2
Partner requested/insisted	1.0
Other/don't know	2.9

Source: LDHS, 2004.

For the reasons why they did not use condoms in their last sexual intercourse, they indicated lack of availability of condoms as their main reason (24.3 percent) in table 4.10. Other reasons were that they did not use condoms because they use family planning methods which do not pose any risk (8.2 percent), respondent wanted to get pregnant (15.6 percent), does not like a condom (21.0 percent) or trusted partner (10.0 percent). Young women did not use condoms at their first sexual intercourse because as it is an unexpected scenario thus communication of condom use was somewhat awkward (Abdullah, Fielding, Hedley, Ebrahim and Luk, 2002). Furthermore, some showed that they were embarrassed to buy condoms, using alternative contraceptives and wanted to express love and pleasure. Manlove, Moore, Liechty, Ikramullah and Cottingham (2005) indicate that some young teenage girls did not use condoms because they were forced by their older partners who did not like condoms.

**Table 4.10: Percentage distribution of young people aged 15-24 years by reasons did not use a condoms at their last intercourse**

Characteristic	Percentage
<b>Reasons did not use a condom</b>	
Not available	24.3
Cost too much	0.5
Used family planning method	8.2
Condoms transmit HIV	0.3
Condoms have worms	0.5
Trusted partner	10.0
Partner was negative /no risk	2.3
Respondent doesn't like	21.0
Partner refused	9.1
Respondent wanted to get pregnant	15.6
Other	8.3

Source: LDHS, 2004.



#### **4.5.2 Multivariate analysis of condom use**

As it has been mentioned before, condoms play an important role in young people's live by sustaining their sexual behaviour and reproductive health as they prevent them from being infected. Condom use at last sexual intercourse was found to be significant with control variables: age of a woman, marital status, wealth, discussion of family planning with a partner and type of place of residence.

Table 4.8 indicates that teenagers aged 15-19 are 1.3 times more likely to use condoms than the youth in the age-group 20-24. This may be because condoms are available everywhere thus teenagers save time to go to the clinics and are able to study. Whereas young adults in the ages 20-24 are using other family planning methods as they will not be humiliated by service providers because of their maturity and responsibilities. However, the observation is that age seems to lose its strength on condom use as more predictor variables are added to the model.

Marital status of young women have an influence on condom use. The likelihood of never married women to use condoms at their last sexual intercourse was from 10.7 to 11.6 times more than those who were married/living together. However, the effect of condom use on never married women seem to have reduced after the inclusion of other variables in the model. This was also justified by Mahler (1996) indicating that single Norwegian women had the higher likelihood of using condoms at their last sexual intercourse more than married or cohabiting women (19% compared to 10%,  $p < 0.002$ ). Women who are married or living together with their partners have a negative effect on condom use.

**Table 4.11: Odds ratios of condom use at last sexual intercourse by selected characteristics**

Characteristic	Model 1	Model 2	Model 3
	Odds ratio	Odds ratio	Odds ratio
<b>Age</b>			
15-19	0.494***	1.138	1.228
20-24 (ref)	-	-	-
<b>Marital status</b>			
Never married	11.662***		
Married/Living together (ref)	-	-	-
<b>Total children ever born</b>			
None	1.244	0.070***	0.056***
One	0.901	0.998	0.862
Two (ref)	-	-	-
<b>Discussed FP with a partner</b>			
Never		0.548*	0.645
Once or twice		0.967	1.040
More often (ref)			
<b>Type of place of residence</b>			
Urban		1.682*	1.477
Rural (ref)			
<b>Highest educational level</b>			
No education			0.000
Primary			0.000
Secondary(ref)			-
<b>Wealth Index</b>			
Poorest			0.805
Middle			1.305
Richest (ref)			-
<b>N</b>	3217	3217	3217
<b>log likelihood</b>	886.532	882.275	861.83

Source: LDHS, 2004.

\*Significant: \*p≤0.05, \*\*p≤0.01, \*\*\*p≤0.001, ref= reference category

Total number of children ever born by a woman showed a highly statistical significance on condom use at last sexual intercourse in almost all the models. Young women who had not yet had children are 3.9 times more likely to use condoms than those who had at least one child. It was also observed that the effect of children ever born on condom use decreases as other independent variables are added to the model.

Young people who reside in urban areas have the higher likelihood significance, 1.7 times of using condoms at their last sexual intercourse than the rural areas dwellers. This is the case because of traditional norms and cultural restrictions concerning young people's sexual behaviour as pointed by other scholars. Negative attitudes towards young people by reproductive health service providers has an impact on the use of condoms leading to lack of access and utilization of family planning methods as adolescents reluctantly go to the clinics. Adolescents who indicated not discussing family planning with their partners were about half (odds ratio=0.548) times using condoms to those who discussed family planning more often with their partners. However, the results show almost an equal level of condom use (odds ratio=1.040) for those who discuss family planning once or twice with their partners to the reference category in the last model.

#### **4.6 Conclusions**

The results showed high knowledge of contraception among young sexually active women in Lesotho. However, levels of contraceptive use is very low hence implying that knowledge of contraception does not necessarily mean contraceptive use. This indicates that adolescents are still at the risk of premarital pregnancies and prone to sexually transmitted infections including HIV/AIDS. Furthermore, young women who were sexually active were from the rural areas than from urban areas and also sex increased with age where those aged 20-24 were more than those aged 15-19 years. Young people had different perceptions regarding contraception where people were concerned about side effects. Moreover, some of them indicates that they find it awkward to obtain contraceptives at the clinics and public places. They also showed that they use condoms at the beginning of the relationship as they have not known each other well but as the relationship develops along they do not feel the necessity of using them because they gain trust and tacit permanent. Akande (1997) posit that black south african adolescents' perception about condoms were that they do not need to use condoms because their relationships pledged to be of the long-term thus sexually warranted and presumed to be permanent.

Information to the youth emphasizing the importance of condom use with each partner to prevent unwanted pregnancies and STI/HIV as they have been documented to have multiple relationships by other researchers is needed. Furthermore, young people need to be informed to supplement other methods of contraception with condoms as other methods prevent

pregnancies only while adolescents continue to be at the risk of contracting STI/HIV. The results showed the need for more information because it had revealed that some of the youth in Lesotho believe that if their partners have been tested HIV negative they are free from contracting the disease thus no need to use condoms. This indicates that young people lack information about their reproductive rights. However, young women who had not yet have children have a higher likelihood of using condoms at their last sexual intercourse and those who are never married may be not ready to raise children. Although in Lesotho, the Roman Catholic Church is known to strongly condemning the use of contraceptives, however the results showed a different picture where adolescents from the Catholic church do use condoms more than other denominations.

Independent socio-demographic and economic characteristics were selected for logistic regression analysis in relation to contraceptive use. Age, total children ever born, type of place of residence and educational level showed a positive relationship with contraceptive use. However, it was observed that when place of residence and education were included in the model there was a small percentage decrease in the strength of their relationship. Multivariate results indicates no relationship between condom use at last sexual intercourse and educational level among young sexually active women. This was also observed in the type of place of residence whereby many researchers found a higher proportion of contraceptive use in urban areas because of easier access of health services. This contradicts the bivariate results and literature review which showed a positive relationship of condom use and education. The more people are educated the more they gain information and able to utilize their knowledge as they know the benefits. Sexual health service providers should be trained to be user-friendly to young people's need of family planning methods because the reality is that they are sexually active irrespective of traditional norms and religious beliefs encouraging abstinence until marriage. Young people who communicate with their partners have the higher likelihood of using condoms as they have the opportunity to negotiate safer sex. This will prevent them from contracting infections or increasing premarital childbearing.

## **CHAPTER FIVE**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter will present the conclusions drawn on the findings of the study as well as the recommendations. The study determines the socio-demographic and economic characteristics of family planning knowledge, young people's attitudes towards contraceptive use, availability and accessibility of family planning health facilities.

#### **5.2 Summary of findings**

Adolescents of Lesotho have a high knowledge of family planning methods especially condoms followed by injectables and pills. Condoms are universally known by young people in Lesotho because of promotions by different youth groups such as Phela and Positive Action as a way to encourage others to prevent unintended pregnancy and STI's including HIV/AIDS. However, there is still a low level of contraceptive use with 10.4 percent of current condom use which shows that knowledge of contraceptive use does not involuntarily mean use of contraception. This shows that most of young women are still vulnerable to unplanned pregnancies especially at their first premarital sexual encounter. It therefore implies that the ministry of health as the governing body has a long way to convince them to use condoms consistently and correctly.

Furthermore, provision of several types of contraceptive methods would help adolescents to effectively protect themselves from the risk of premarital pregnancies. Most of these young people showed that the reasons they are not using contraceptives is because of their side effects and they were not told about them by service providers. Others felt embarrassed to take pills in their parents or partners presence which led them skipping days thus exposing them to the risk of conceiving if they engage into sexual relations in these periods. Lack of information about other family planning methods hinders young peoples' access hence failure to contraceptive use. This shows that in Lesotho family planning programs are failing to target the youth who are indeed sexually active. Promoting sexual discussions with young people in resisting the pressure to engage in sexual relations and be able to negotiate safe sex especially women will enable them to protect themselves (Kiragu and Zabin, 1995).

It was also observed that knowledge of contraceptive methods varies by urban and rural areas. The results showed modern methods being commonly used by adolescents' from the rural areas. They further showed no significant association of contraceptive use and educational attainment of young people. Parents, teachers and healthcare providers have to accept the current situation regarding adolescents' sexual activities and do away with the fear that young people's contraceptive use will lead them to promiscuity and permissiveness because indeed they are sexually active. That is, they should have skills of providing their children with sexual issues as it is better for them to use contraceptives for protection if they cannot abstain. This is because parental control over their daughter could bring risky behavior as they would want to experience. Mberu (2008) asserts that the partnership of healthcare providers and the societies can use cultural and sensitive approaches to provide information in the language that suits young people about their rights on family planning methods.

Wealth can also be considered as a determinant of contraceptive use, because women with high socioeconomic status are more likely to use contraceptives, as they can afford the costs. The implication might be that those from lower status can be hindered by costs of family planning methods to be the frequent users. Thus, family planning managers may at least subsidize the costs in order to have efficient utilization of methods from every angle of the population at risk. The results also showed that adolescents use condoms with their so called casual partners than with their steady partners known as long time relationships. One of the reasons indicated is that, in the long run, they end up trusting each other such that they do not find it necessary to use condoms.

The logistic regression analysis further indicated a higher level of condom use at the younger ages (15-19) than those in 20-24 years. This might be that most of these younger ones are still at high school level; they use condoms in order to prevent pregnancy as they will be expelled from school if pregnant. However, the 20-24 year-olds might be married or in universities where they can still attend while pregnant. Type of place of residence by use of condoms showed urban adolescents to use condoms more than their rural areas counterparts. This can be explained by the fact that condoms are found everywhere in public places in urban areas. Their promotion through media is efficient in urban areas where it is easily accessible while in some rural places they cannot access any radio or television network in Lesotho.

Sexual reproductive programmes should be strengthened to emphasise on the multiple benefits that condoms have as a starting point. This is crucial because if young people use other family planning methods only, they are still at the risk of contracting diseases. Thang and Anh (2002) also indicated that providing information and maximizing access to contraceptives to the target population will be a good measure to fulfill the goals. Strong campaigns about contraceptive use will promote and increase their utilization by adolescents. The use of pamphlets or posters will be essential in providing information on reproductive issues and made widely available to young people. This communication material be easier to understand if the discription of contraceptive methods could be written in the local language, sesotho. Family planning providers attitude is an important factor in influencing clients use of contraceptives. They should contribute in improving their services towards adolescents.

### **5.3 Recommendations**

Findings showed that young people are knowledgeable about condoms but less likely using them. Government of Lesotho with the aim of reducing high unintended premarital childbearing and high prevalence of HIV/AIDS among adolescents, intensive programs informing young people about their reproductive decision-making is needed. This should apply in both rural and urban areas, as most of the time adequate resources are located in the urban areas. The majority of women reside in the rural areas where effort should be enforced for the services. This implies that family planning facilities need to be available in all parts of the country to those who are in need of them. Meeker and Klein (2002) pointed out that implementation of programs that will assure young people about the risk of HIV infection due to their sexuality would be useful. This could dismiss the myths that chances of being infected are lesser with regular partner. Although education is shown as one of the most predictors of contraceptive use, however, the logistic results showed no significance. This indicates that most of the educated young women in Lesotho do not necessarily use contraceptives hence why there is a need to provide adequate information on the importance of contraceptive use. Furthermore, men should be the targeted population in this issue of family planning, as it has been shown that they do not like them. The results may be positive as they will end up accepting family planning services.

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