Unintended pregnancy and barriers to contraceptive use: Perspectives of University students in Lesotho

By

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DECLARATION

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 Master's 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. An editor was used for proofreading.

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Date

ABSTRACT

Unintended pregnancy has been the subject of considerable research in Lesotho. Lack of priority placed on young people's sexuality and reproductive health was found to be a major factor exacerbating the rate of unintended pregnancy in the country. The study draws on qualitative data collected from in-depth interviews with university students in Lesotho. In total, 15 in-depth interviews were conducted with 10 women and 5 men. The findings of the study show that unsafe sex coupled with low contraceptive use are the leading causes of unintended pregnancy among young women in Lesotho. Evidence suggests that even though contraceptive prevalence is noticeably low, modern contraceptive methods have a greater potential than other means for reducing the prevalence of unintended pregnancy.

The findings of the study also suggest that there is a considerable gender differences in sexual behaviour; males are more likely than females to experience earlier sexual onset, have more sexual partners and to practise unsafe sex. This study recommends that increasing contraceptive prevalence among young people will lead to better reproductive health outcomes. The study also suggests that family planning services should be more male friendly because men play a major role in decision making, and have a great influence on their partners' decisions to use contraceptives.

Key words: Lesotho, young people, sexual behaviour, contraceptives, unintended pregnancy

DEDICATION

This thesis is dedicated to my Mother Mrs ‘Makelebone Mats’umunyane, who never failed to give me moral support. Mama, you never had anything to give me, but your love was the only hope I had. I watched you laying down your life for me to live. I thank God for giving you strength to go through all the hustle for me to see the future.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBR	Crude Birth Rate
FSH	Follicle Stimulating Hormone
GDP	Gross Domestic Product
HIV	Human Immune-deficiency Virus
HBM	Health Belief Model
IUCD	Intrauterine Contraceptive Device
LDHS	Lesotho Demographic and Health Survey
LH	Luteinizing Hormone
LPPA	Lesotho Planned Parenthood Association
NFP	Natural Family Planning
NUL	National University of Lesotho
OC	Oral Contraceptive
SCLT	Social Cognitive Learning Theory
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
TPB	Theory of Planned Behaviour
USA	United States of America
USAID	United Agency for International Development
WHO	World Health Organization

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Chapter One

Introduction and Background

1.1 Introduction

Research shows that the world fertility transition began two hundred years ago (Strulik and Vollmer 2010) but the fertility decline first occurred in developed countries in the beginning of the 19th century (Caldwell and Caldwell 1987; Bongaarts 2002), and in the 1930s the crude birth rate (CBR) and other period indices of fertility in most developed countries reached their lowest points (Glass 1968). Bongaarts (1998) argued that historically, declining mortality has been the main cause of the fertility decline in the world. Strulik and Vollmer (2010, p1) also stipulated that "in almost all cases the fertility transition was led by a secular fall of mortality rates, so that it seems that decreasing mortality rates have caused fertility to fall". In general, this highlights that a higher standard of living, better nutrition, expanded health services and other factors have increased life expectancy by 50%, and a further decline is likely (Bongaarts 1998).

The speed and magnitude at which the fertility transition occurs has been comparatively lower in Sub-Saharan African countries than in other regions of the world (Cleland 2001; Caldwell and Caldwell 2002). This poses the question of whether the fertility transition is indeed a worldwide phenomenon or whether there exists a "fertility trap" that hinders some countries from following the path of historical leaders (Strulik and Vollmer 2010). Most of the fall in fertility among African women occurred only in the 1980s (Timaeus and Moultrie 2003). Research highlights that in South Africa fertility began to decline earlier than the official estimates suggest, dropping by 10% before the end of the 1960s, marking the onset of African fertility transition (Timaeus and Moultrie 2003). In the other African countries as Cohen (1998) indicates, the fertility rate was still very high (between 5.5 and 7.4) around 1960s. This was caused by the desire for a large family size among African women in contrast with, for example, Asia and Latin America (Kirk and Pillet 1998). Research shows that recently (around the 1990s) in most Sub-Saharan African countries the total fertility rate (TFR) was still 5.0 (Cohen 1998; Caldwell and Caldwell 2002). Generally research indicates

that the total fertility rate (TFR) in less developed countries declined from about 6.0 in the early 1950s to about 2.5 today, while in more developed countries the TFR was already below the replacement level since around 1990s (Bongaarts 2002; Bremner et al. 2010). According to Cohen (1998), some Sub-Saharan countries are more resistant to fertility transition because of social organization and traditional attitudes which encourage prolific childbearing.

Modern contraceptives methods, prevalent in almost every country, are currently considered the most effective **tools** with which to fight high fertility levels worldwide. Caldwell et al. (2002) in their study of fertility transition in Sub-Saharan Africa show that the global fertility transition essentially has been achieved by new contraceptive methods that became available around the 1960s, and that future declines in fertility will depend directly on the increased use of modern contraceptives. They even suggest that changes in the level of contraceptive use might be used to estimate changes in fertility levels in order to project the size of future populations and the rate of unintended pregnancy. However, a range of factors also influence contraceptive use, especially among young women. This study will investigate levels of knowledge of methods of contraceptives, as well as accessibility and availability of contraceptive methods. It will also assess factors contributing to a high rate of unintended pregnancy among young women in Lesotho.

Unintended pregnancy has become a public concern and is capturing a great deal of attention because of its high prevalence rate in continent. Singh et al. (2010) define unplanned births as those occurring two or more years sooner than desired, or not wanted at all. The statistics show that in the 1990s, unintended pregnancy was over 40% in some African countries where sexual activity is high among adolescents and 17% in other countries where adolescents' sexual activity is low (Meekers 1994). Recently, unintended pregnancy in Africa was reported to be 57 per 1000 women (Singh et al. 2010). As Singh et al. (2010) indicate, the observed intended and unintended pregnancy rates are highest in Africa (136 and 86 respectively) than in other regions. This goes together with a low contraceptive prevalence rate in the less developed countries when compared with developed countries. Maulding and

Segal (1988) indicated that contraceptive prevalence was very low in most developing countries until the 1960s.

1.2 Fertility trends in Lesotho

Lesotho is a small mountainous country with a population of around 2.3 million. It is said to be one of the poorest countries in the world with a gross domestic product (GDP) estimated to be 9.013 billion. The country is facing high levels of unemployment, poverty and HIV/AIDS (Matlosa 2006). It is one of the top four countries in the world with the highest prevalence rate of HIV/AIDS estimated at 24% among the adult population aged 15-49; there is also a high rate of teenage and unintended pregnancy of about 52% (Akintade 2010; LDHS 2009). Lesotho has a youthful population, with half of the population under 20 years old and only 7% 65 years old and older; this has serious implications for age and economic dependency (United Nations 2004 in Matlosa 2006; LDHS 2009). More than 95% of the population is Basotho, and the most dominant religion is Christianity (Levinson 1998). According to LDHS (2009) the population of Lesotho is predominantly rural. In 1996 the urban population was only 17% of the total population but it increased to 23% in 2006, with a further increase expected (LDHS 2009). The results indicate that since then Lesotho's population has not increased greatly. More details about the country are given under research setting in chapter three.

Lesotho has been experiencing a steady fertility decline over the past few decades. The latest Lesotho Demographic and Health Survey (LDHS) results show that in the mid 1970s the total fertility rate (TFR) was 5.4%, declining to 5.3% in the 1980s; the most recent survey gives it at 3.3% (LDHS 2009). Studies show that even though there is a decline in the fertility rate in Lesotho, the rate of unintended teenage pregnancy is increasing at an alarming rate compared with previous years, and this contributes to a slow fertility transition (Akintade 2010; LDHS 2009). Despite a steady rise in the level of modern contraceptive prevalence and its use in Lesotho, more than half of pregnancies are unplanned (LDHS 2009). Recent research shows that in Lesotho more than 50% of pregnancies are unplanned, and 41% of those pregnancies are in women below the age of 20 (LDHS 2009; Akintade 2010). Again, the results of the

2009 LDHS show that in Lesotho 80 births per 1,000 women are occurring among young women aged 20-24 years.

1.3 Rationale for the study

Preston Whyte (1991) argued that young mothers face many psychological and emotional challenges because of being rejected by their parents, partners and peers. This situation is also experienced by young mothers in Lesotho as premarital fertility is still highly unacceptable. Young women falling pregnant before marriage thus face the significant challenge of being rejected by their communities. They are given humiliating names because society considers them ‘rotten’ or ‘spoilt’ (Mturi and Moerane 2001). In fact, as the authors indicate, society considers those girls falling pregnant before marriage as destroyed or useless. A girl who falls pregnant before marriage brings shame to her family, and this prompts parents to ill-treat their children, hence they are rejected and sometimes expelled from their own homes. Research indicates that young unmarried women who fall pregnant also face a range of challenges such as being expelled from school, hence quitting their education at a very early stage (Phafoli et al. 2007). Research generally shows that poor education leads to poor employment and poor financial prospects which in turn may have a detrimental effect on all spheres of life of the mother and her baby (Preston-Whyte 1991). The situation in Lesotho, however, is changing with pregnant young girls facing less stigmatization than in previous years (Mturi and Moerane 2001).

Unintended pregnancy among young women in Lesotho contributes to other reproductive and health problems such as a high rate of induced abortions and neonatal and maternal deaths. Studies show that most reproductive health problems occur among younger women because of age-related vulnerability, interaction of biological and social factors and declining ages at menarche (Zabin and Kiragu 1998). According to Phafoli et al. (2007), high neonatal and maternal morbidity and mortality among young women is also a result of the delay in attending antenatal clinics, hence delaying treatment of pregnancy complications. Maternal death rate in Lesotho is estimated at 11% of all women age 15-49 (LDHS 2009). Because abortion is still illegal in Lesotho, it may be difficult to find clear statistics on the rate of

abortion in the country, though Mturi and Moerane (2001) argue that in Lesotho most abortions in the 1990s were conducted under primitive and dangerous conditions. It is important therefore to look at factors influencing unintended pregnancy, finding out whether there is anything that can be done to change the situation.

In Lesotho, unintended pregnancy is currently seen as a major problem facing the country; young unmarried Basotho women are mostly affected by unintended pregnancies. There is a range of factors contributing to unplanned pregnancies, especially among young women. The growing rate of premarital sexual activities in Lesotho which became increasingly common around 1990 contributes to a high rate of unintended pregnancy's prevailing in the country. For example, Makatjane (2002), in a study investigating the prevalence of premarital sex and childbearing in Lesotho, found that premarital sex has more than doubled between 1977 and 1992. This is the time when traditional norms and values of societies concerning reproductive lives of young people start to be less effective and sexual behaviour of young people were no longer monitored by the elders (Makatjane 2002).

In Lesotho today, a significant proportion of young Basotho men and women start to have sex at the age of 15 (LDHS 2009). Beside all this evidence that young people engage in sexual activities at early stages of their reproductive lives, there is still a denial by communities that young women are sexually active. Parents and health care providers are therefore reluctant to discuss safer sexual practices with young people. The stigma attached to premarital sexual behaviour contributes to young people's hiding their sexual activities; as a result they are more likely to experience negative reproductive health outcomes such as pregnancy and sexually transmitted infections (STIs). As Phafoli et al. (2007) indicated, health workers are often very judgemental in their attitudes towards pregnant school girls. Young people thus have to overcome significant obstacles to obtain information and care which they need to have safer sexual relationships. Studies highlight that because of lack of information young people have to guess what is right or wrong, and in some cases, fail to resist peer pressure to initiate sexual intercourse (Mturi and Moerane 2001). In this study young people's perceptions of risky sexual behaviour will be explored, as well as their knowledge and attitudes towards the use of modern contraceptives.

An increase in sexual activity by young people signifies an increase in demand for contraception. Dixon-Mueller and Germain (1992) explain an unmet need in a broader sense to include those who use inefficient methods of contraception, those using effective methods incorrectly, and those using methods which are unsafe or unsuitable for them. As young people enter their reproductive ages, they become more vulnerable to risky sexual behaviour that contributes to pregnancies and other undesirable consequences such as sexually transmitted diseases (STIs). The highest percentage of unmet need is seen in Sub-Saharan African countries, ranging between 20-25 per cent. Bongaarts and Bruce (1995) indicated that the percentage of unmet need in this region exceeds contraceptive prevalence. Unmet need is higher among unmarried women than married women in Africa, but the proportion of unmet need among unmarried women is quite significant (more than 33%). Studies, however, cannot find appropriate data which defines unmet need for unmarried women because, as indicated by Dixon-Mueller and Germain (1992), the level of unmet need fluctuates widely according to the stringency of the definition being used. According to the LDHS (2009), 23% of married women have an unmet need; studies show that unmet need is higher among unmarried young women than other women (Akintade 2010). There are several reasons that women give for not using any method of contraception. According to Bongaarts and Bruce (1995), an unmet need for contraception exists because there is a cost associated with practising contraception, or there is a lack of information about it.

1.4 Objectives of the study

The overall objective of this study was to investigate factors influencing unintended pregnancies among young women and barriers against effective contraceptive use.

The specific objectives were:

- To ascertain perception of risk of unintended pregnancy
- To explore risky sexual behaviour among young people that leads to unintended pregnancy
- To explore awareness of and attitudes towards contraception

- To identify barriers that affect contraceptive use by young people in Lesotho

The key questions which were addressed include:

- Is unintended pregnancy a serious problem among young people?
- Are contraceptive methods accessible and available to young people?
- What factors hinder young people from accessing contraceptives?
- Are young people aware of sexual behaviour that increases the risk of unintended pregnancy?

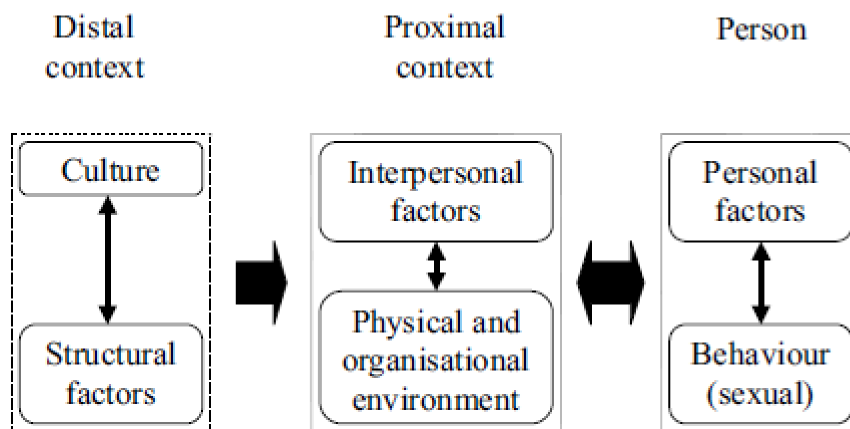
1.5. Theoretical Framework of the Study

This study draws on two major theories explaining factors influencing unintended pregnancy: a model of sexual behaviour developed by Eaton et al. (2002) and the analytical framework of the determinants of fertility. This dissertation outlines the theories and their relevance to the study. The model of sexual behaviour was used mainly to explain factors influencing risky sexual behaviour that lead to unintended pregnancy, and the analytical framework of determinants of fertility was used to explain other factors leading to an unintended pregnancy.

A model of sexual behaviour was developed around the 1990s; it has been a major theory used to explain young peoples' risky sexual behaviour that perpetuates the high rate of unintended pregnancies and sexually transmitted infections (STIs) (Eaton et al. 2002). The model of sexual behaviour developed by Eaton et al. (2002) was adopted after several other theories of sexual behaviour such as Health Belief Model (HBM), Theory of Planned Behaviour (TPB), and Social Cognitive Learning Theory (SCLT), and it is meant to include both subjective and objective influences. Conner and Armitage (1998) defined subjective norms as the individual's perceptions of general social pressure to perform or not perform the behaviour. On the other hand they indicate that objective norms determine an individual's global positive or negative evaluation of performing a particular behaviour, and the more favourable the attitude towards the behaviour, the stronger would be the individual's intention to perform it.

According to Eaton et al. (2002), this model mainly focuses on factors within the triad; personal factors, interpersonal factors and processes that perpetuate young people's unsafe sexual behaviour. They define personal factors as forces within a person including beliefs and knowledge that influence certain attitudes and behaviour. For example, knowledge and beliefs about condoms will influence its use. Personal factors also include the perception of exposure to risk. According to Bandura (1998, p2), 'if people lack awareness of how their lifestyle habits affect their health, they have little reason to put themselves through the misery of changing the bad behaviour they enjoy'. Proximal or interpersonal factors are those coming from the external world such as physical and organizational environment, while distal factors are cultural and structural factors influencing risky sexual behaviour (Eaton et al. 2002). The relationship between sexual behaviour, personal factors and proximal and distal context are explained in Figure 1.1 below;

Figure 1.1- Model of sexual behaviour



Source: Eaton et al. (2002)

According to Hingston et al. (1990), young people's risky sexual behaviour can change if they believe that they are personally susceptible to HIV exposure; the consequences of exposure are severe; protective measures such as condom use are effective in preventing transmission and if they perceive few barriers to the use of condoms.

In the context of unintended pregnancy, personal factors will include people's knowledge and beliefs about contraceptives and certain sexual practices. Proximal or interpersonal factors are those coming from the external world such as the physical and organizational environment, for example, availability and accessibility to contraception. Proximal or interpersonal factors will also be looked at in terms of other influences of sexual behaviour and contraceptive use coming from external world, such as peer pressure, communication with parents and health workers and interaction with the community. Distal factors are cultural and structural factors influencing risky sexual behaviour (Eaton et al. 2002). Distal factors in this context will include economic, social and cultural factors influencing certain sexual practices and barriers to contraceptives use.

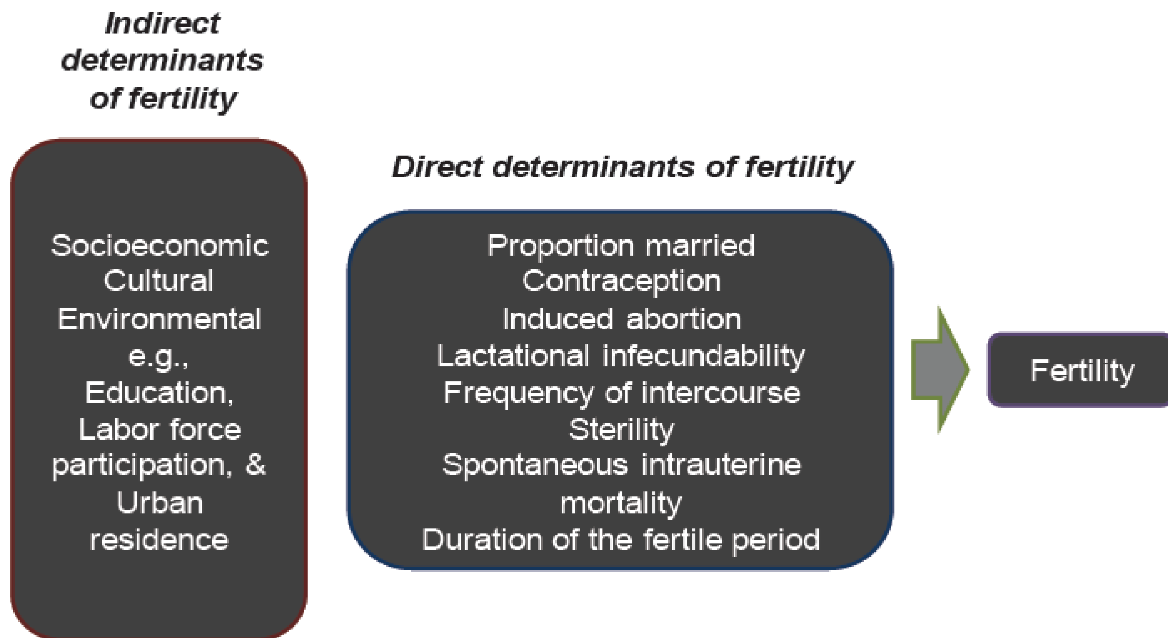
The analytical framework of the determinants of fertility which was developed by Davis and Blake (1956) is useful in explaining how socio-economic, cultural, environmental and biological factors affect fertility (Palamuleni et al. 2007). Because the model of sexual behaviour by Eaton et al. (2002) focuses mostly on indirect determinants of fertility, it is essential also to explain direct or intermediate variables that affect women's fertility using the analytical framework of determinants of fertility. The analytical framework theory was later adopted by Bongaarts first in 1978 and modified it again in 1985. It highlights two main determinants of fertility: direct and indirect. Direct determinants are considered the ones that directly affect a woman's fecundity such as family planning methods and abstinence, while indirect or intermediate variables include socio-economic and cultural systems and include factors such as education, rural-urban residence, religion, technology and other factors that indirectly affect fertility (Palamuleni et al. 2007). This theory is used in this paper to explain direct as well as indirect determinants of fertility that influence the rate of unintended pregnancy and barriers to contraceptive use in Lesotho.

According to this theory, improvement in socio-economic status of women is a major cause of fertility decline. Much research that has been done to review women's socio- economic status and its impact on fertility shows that there is a negative correlation between the two (Kirk and Pillet 1998; Garenne 2004). Education, which is directly linked to higher socio-economic status, has a negative impact on fertility**.** Research highlights that education

attainment generally has a depressing effect on fertility through the adoption of small family norms; the knowledge and use of contraceptives, and older ages at first union and birth (Kirk and Pillet 1998). Palamuleni et al. (2007) using the theory of proximate determinants of fertility in South Africa also indicated that education on its own has an influence on other fertility variables such as age at first marriage, desire for children, contraceptive use, and many other determinants of fertility. Age at first marriage is also considered the most significant variable influencing fertility. Many studies show that the marriage rate among the female population plays a crucial role in that population's birth rate and in some populations as indicated by Hinde (1998), fertility is mainly determined by the proportion of female population that is married.

Bongaarts et al. (1984) outlined the list of proximate determinants of fertility as follows; proportion of women married or in sexual unions, frequency of intercourse, postpartum abstinence, lactational amenorrhoea, contraception, induced abortion, spontaneous intrauterine mortality, natural sterility and pathological sterility. Of all these variables, it was found that contraception is the most influential determinant of fertility; research suggests that family planning programme has a stronger effect on aggregate fertility change than does the level of development and the rate of economic growth (London 1988). Research shows that contraceptive prevalence is higher in developed countries than the less developed countries (Glass 1968). According to WHO (2009), it is not only high prevalence rate that influences fertility decline in developed countries, but also the extent to which couples use some form of control, the stage in family building at which control is initiated, and the effectiveness of the method used. Contrary to this, African women use modern contraceptives mainly to improve child spacing, and not to shape total family size, hence modern contraceptives are merely replacing traditional spacing practices (Cohen 1998). Caldwell and Caldwell (1987) show that, Africans support female sexual abstinence rather than modern contraceptive methods. This conforms in a broad term to the slow fertility decline discovered in Africa. Figure 1.2 below signifies a framework for analysing the proximate determinants of fertility. It explains the interaction between direct and indirect (social and economic, and biosocial) factors influencing fertility level;

Figure 1.2 –Proximate determinants of fertility



Source: USAID (2011)

1.6 Organization of the dissertation

This paper is divided into five chapters. Chapter one gives a general overview of the study, in terms of introduction, rationale for the study, aims and objectives of the study, and theoretical framework. Chapter two contains a review of the literature with a particular focus on factors influencing unwanted pregnancy among young people. Chapter three identifies the methods of data collection and sampling techniques, including the data analysis method. Findings of the research are elaborated in this chapter. In Chapter four the findings of the qualitative data are described in great detail using the thematic analysis method. Finally, the last chapter provides conclusions. It also discusses the findings of the study, and gives recommendations for decreasing the rate of unintended pregnancy in Lesotho.

Chapter Two
Literature Review

2.1 Introduction

This chapter explores findings from previous studies which have been done on factors influencing unintended pregnancies and barriers to effective contraceptive use. The literature thus looks at other people's findings and their views and opinions in the previous studies that have been carried out. The main areas that are covered include: knowledge of contraceptives and various methods used in Lesotho, knowledge of a source of supply, and factors contributing to low contraceptive use.

2.2 Knowledge of contraceptives

Knowledge of contraceptive methods plays an important role in the study of young people's reproductive life, because it affects their decision to use such services (Amazigo et al. 1997). The problem of low contraceptive use among young women in Lesotho is still a controversial issue. Many studies have been conducted to explore factors influencing unintended pregnancy, and among others knowledge has fuelled a lot of arguments, and still there is no clear evidence about whether knowledge is one of the contributing factors to low contraceptive use among young women. Caldwell et al. (2002) showed that a demand for contraception has been low in many African countries; and only a few governments have been enthusiastic about devoting efforts to setting up national family planning programmes. Other studies, however, confirm a low use of contraception even when knowledge is high (Olukoya et al. 2001). The authors emphasize that insufficient information about family planning methods and inaccessibility to contraception counteracts the knowledge that young people already have.

In most cases, knowledge of contraceptive methods is not functional because it is normally not accompanied by effective use of such methods. In Lesotho, recent studies show that knowledge and awareness of different contraceptive methods is high among young women, but utilization is very low. For example, the LDHS (2009) results show that 98% of all

reproductive women in Lesotho have knowledge of at least one modern method of family planning, but utilization of such services is only at 47%. The level of awareness and utilization of family planning services was also found to be high among female university students (Akintade 2010), as well as among school-going adolescents in Lesotho (Mturi in Nkambule 2009). However, because contraceptive knowledge does not necessarily balance its prevalence and use, unintended pregnancy is high among young people in Lesotho. The most widely-known contraceptive methods include the male condom, injectables and pills, and the less known methods are female sterilization and intrauterine contraceptive devices (LDHS 2009).

The results of LDHS (2009) indicate that 97% of men and women reported having heard about condoms and 87% have knowledge of injectables, the pill and female condoms. Tuoane et al. (2004) however observed that lack of awareness and poor knowledge of contraceptives methods existed among young women seeking abortion in Lesotho. They clarify that awareness of contraceptives in most communities has been found to be high, but good knowledge of different contraceptive methods together with utilization of such services is very low. The negative attitudes of the older generation towards contraception are also transferred to the younger generation. Nkambule (2009) argued that that low contraceptive use in Lesotho is not only associated with low prevalence, but rather resistance by parents, children, as well as health workers. Knowledge of contraceptive methods is therefore not necessarily the reason for low use among young women.

2.2.1 Family planning system in Lesotho

The most recent Lesotho demographic health survey (LDHS) which was conducted in 2009 shows contraceptive prevalence of 47% and 58% among married and unmarried women respectively. This is a very low prevalence, considering the government’s goal to reach replacement level in 2011. The study which was conducted by Tuoane et al. (2004) indicated that contraceptive prevalence has been increasing slowly up to the late 1990s. This low uptake of contraception adds to the high fertility rate in the country. The reason for low use of contraception in Lesotho may stem from family planning’s being introduced late in the

country, around the 1960s; the idea has not yet spread evenly throughout the country. For example, many people living in rural areas have little knowledge of contraception, and the few who have knowledge of family planning programmes may have less access to them because of lack of family planning clinics in the rural areas. Tuoane et al. (2004) also showed that in the late 1990s contraceptive use was 40.3% and 25.4% for women living in urban and rural areas respectively. The only few antenatal clinics which are available in Lesotho are situated in the main cities where they are not easily reached by most rural women. These differences in the accessibility of contraceptives among women of different geographical areas also exist among the youth and adolescents of different geographical areas. While it is clear that contraceptive use is a problem in Lesotho, it is even more difficult for unmarried young women to access.

The Lesotho Planned Parenthood Association (LPPA), which is funded by the International Planned Parenthood Federation, was first introduced in 1968 to provide family planning services to married women who want to space their births. This is still the main organization donating contraceptives in Lesotho. Before the introduction of LPPA the rate of contraceptive use was very low because of its inaccessibility. According to Tuoane et al. (2004), the Lesotho government only started being directly involved in family planning in the 1970s. They indicated that prior to 1977 the government had a fear of a negative response from the public. The introduction of family planning programmes in government and private hospitals was followed by the establishment of the National Adolescent and Development Programme in 1998, which according to Phafoli et al. (2007) led to the introduction of adolescent clinics which are now referred to as adolescents' corners. Adolescents' corners are, however situated in the main cities where only few, mostly urban individuals can have access to services provided.

In Lesotho, the reproductive and sexual health of young people had been ignored until the introduction of such adolescents' clinics which were established in the late 1990s. Before the introduction of family planning services, women were relying on traditional methods of birth control, such as post partum abstinence, withdrawal and post menstrual period. Post partum abstinence was the most commonly used method of birth spacing, especially among women

whose husbands were away for a long time working in the mines of South Africa. These traditional methods were not even effective enough to reduce the fertility rate in the country. The existence of traditional methods of birth control therefore still has an impact on the high birth rate and unplanned pregnancies among young people in Lesotho.

It is true that the rate at which women are using contraceptives in Lesotho has increased, nevertheless young adolescents and teenagers having little access remains a problem. This may affect the government's goal of reaching replacement level of fertility in 2011. For example, Tuoane et al. (2004) indicated that in 1991 the government had the goal of raising contraceptive use to 31% by 1996, but in 1998 the rate of contraceptive use was only 23%. This means that TFR also is declining at a low pace because of the limited access to family planning services. A low increase of contraception use means a low decline of fertility rate. For example, in Lesotho TFR declined from 5.5% to 5.0% between 1970 and 1986, also from 5.0% to 4.1% between 1986 and 1996. The low level of fertility decline in Lesotho may be influenced by high TFR among young people, which is also influenced by lack of access to family planning.

2.2.2 Knowledge of a source of supply

Information about where men and women of reproductive ages obtain their contraceptives is useful for family planning programme managers and for implementers of logistical planning (LHDS 2009). More studies which are done to explore young people's reproductive lives, however, ignore their knowledge of a source of supply, and this is one of the crucial issues which should be addressed: young people may have knowledge of various methods of contraceptives without knowing exactly where they can access them. Knowledge of a source of supply may differ according to geographical areas or level of education. For example, young people from urban areas may have more knowledge of where to obtain contraceptives than their rural counterparts. This is owing to the fact that, in urban areas there are more sources of information such as media (televisions and radios) and publicity (newspapers), which are not necessarily available in rural areas.

According to the the LDHS (2009), 12% of urban women and men are exposed to messages through television compared with 3 per cent of women and men in the rural areas. It is indicated further that exposure to family planning messages through the radio varies markedly by ecological zone, ranging from 17% to 22% of women in the foothills and in the lowlands zone respectively. In relation to educational levels, more educated women are more likely to be exposed to family planning messages than the less educated ones. Akintade (2010) in the study of contraceptive prevalence at National University of Lesotho (NUL) found that two thirds of respondents are aware of the availability of family planning services on the university campus.

2.3 Mostly used contraceptive methods in Lesotho

2.3.1. Hormonal methods

These are the most commonly used methods of contraception used in Africa. Injectables are more reliable than pills and the side effects do not cause long-term sterility (Hubacher et al. 2008; Castle 2003). In Lesotho it was found that 41% of all women using contraceptives were using injectables in the late 1990s (Tuoane et al. 2004). LDHS (2009) also show that currently 19% of all reproductive married women in Lesotho use injectables. Oral contraceptives on the other hand prevent pregnancy primarily by suppressing ovulation; it blocks the production of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) (Castle 2003; Akintade 2010). It is reported to be the most effective method of temporary birth control, producing 99.9% reduction of conception (Harlap and Eldor 1980). According to LDHS (2009), 13% of all married women in Lesotho are reported to be using this method of contraceptive.

2.3.2. Emergency pill

This method of contraception is not very common, especially in less developed countries, and Lesotho is no exception to this. It is a form of oral contraception which must be used within 72 hours of unprotected sexual intercourse (Jackson et al. 2003). Lakha and Glasier (2006) also call it a dedicated product and they show that in much of Sub-Saharan, the former Soviet

Union and the Middle East, a dedicated product is not available. Knowledge of this type of contraception is much higher in more developed countries. For example, in 2000 the percentage of women undergoing abortion who had tried the emergency pill contraception in USA was 1.3%, 2.9% in Sweden, and 9.2% in France (Lakha and Glasier 2006). Jackson et al. (2003), however, argued that knowledge and use of emergency contraceptive is limited even amongst some developed countries. In developing countries, accessibility of this type of contraception is the main problem for its limited use. For example, Lakha and Glasier (2006) indicated that in Nigeria 2001, 58% of females who had had an abortion knew about emergency contraception but only 2% had ever used it. Lack of knowledge of how and when to use emergency contraception, difficulties with getting hold of it, and reservations about using it are all commonly cited barriers to its use (Lakha and Glasier 2006). That is, 'whether emergency contraceptive can fulfil its potential for decreasing unintended pregnancies depends on the ability of a women's ability to obtain and use it' (Jackson et al. 2003, p8).

2.3.3 Condoms

This method of contraception works mainly to prevent pregnancy as well as sexually transmitted diseases (STDs). It can be used with other modern contraceptives in order to provide dual protection. This method of contraception is found to be the most accessible and easy to use, with the male condom found to be the most dominant. In Lesotho, 9% of married women rely on the male condom for birth control. In addition to male condoms, the female condom has been developed; this is a relatively new method which gives women control of a barrier method and provides some STIs protection (Akintade 2010). Condom use for pregnancy prevention has been increasing in most African countries with the rate more than 5% between 1990s and 2000 (Cleland and Ali 2006).

2.3.4. Female and male sterilization

Akintade (2010) calls this method a permanent method of contraception. This is because by its nature it is not reversible. It is mostly used by older women who no longer wish to have children for their entire reproductive lives. This method is used for conception termination

rather than postponement. It is a very effective method accounting for only 0.5% and 0.15% failure rate for women and men respectively (Hubacher et al. 2008). This method is less common among contraceptive users. For example, in Lesotho only 2.4% of people were reported to have under gone sterilization and vasectomy in the late 1990s (Tuoane et al. 2004). Research however indicates that female sterilization is one of the protection methods that are growing in popularity (Ruminjo and Lynamt 1997). For example, as the authors indicate, in South Africa the association for voluntary sterilization of South Africa was established in the 1970s; since then the number of women and men going for sterilization has been increasing. Male sterilization is still very low in Africa because men believe that it is the duty of women alone to control fertility. For example, most studies done in Sub-Saharan Africa show that almost all men may have knowledge of male sterilization although they do not subscribe to this method (Bertrand et al. 1989).

2.3.5. Implants

Contraceptive implants are also another type of short-term hormonal methods used in Africa. This kind of contraceptive method was first introduced in Africa in the 1980s (Harlap and Eldor 1980). Implants are also normally used by older women with the intention of limiting births rather than birth spacing. There are different types of implantable contraceptives such as Norplant, Jadelle, and Implanon. Even though Harlap and Eldor (1980) indicated that the oral contraceptive (pill) is the most effective contraceptive method, Hubacher et al. (2008) believed that implants are more successful compared with other hormonal methods. They showed that of 1000 women taking this type of contraceptive, only 24 may experience unintended pregnancy. Implants however are associated with many negative impacts such as headaches, weight gain, dizziness, mood changes and acne (Brache et al. 2001). According to Tuoane et al. (2004), more than 10% women in Lesotho use implantable methods of contraception to limit their births.

2.4 Abortion

Besides the above-mentioned modern contraceptive methods used in Lesotho, some women faced with an unwanted pregnancy also resort to abortion, however, the role of abortion is in effect assumed, because it is rarely quantified, owing to the lack of available data on the subject (Palamuleni et al. 2007). According to Hubacher et al. (2008) the annual abortion rate in Sub-Saharan Africa may be estimated at 33 per 1000 women. Studies, however, show that in most of Sub-Saharan Africa countries, abortion is still illegal unless it is performed for health reasons, and women therefore resort to illegal and unsafe abortions. This means the data that is available for abortion is not accurate because it is performed under very secretive situations. It is indicated that a number of women use dangerous chemicals, herbs and some physical actions to terminate their pregnancies (Mturi and Moerane 2001).

Induced abortion rate is found to be higher among young women; this is found to be contributing to growing burdens in hospitals. Guillaume (2003) indicates that women working in service sectors and craft workers have the highest probability of aborting, while housewives and students are less likely to have resources to abortion. Research conducted around the 1990s shows that unintended pregnancy has been there in African countries but there was little if any intention to resort to abortion because of the low number of women who were participating in the public sector domain of paid jobs. Lesotho is also one of the countries with a high abortion rate. For example, Mturi and Moerane (2001) found that in 1992, 23.1% of those who had ever been pregnant had undergone induced abortion. This number is still an underestimate of the rate of abortion in the country because it incorporates only abortions which ended in hospitals owing to complications.

Other modern methods that are offered by African family planning programmes, though at a very low rate include diaphragm and spermicides. Akintade (2010) shows that there are other new delivery systems for hormonal contraception, and those are vaginal rings and transdermal. In Lesotho, a considerable number of currently married and unmarried (47% and 58% respectively) women rely on modern contraceptives for birth control (LDHS 2009). Besides all these modern contraception there are still some traditional methods used to

prevent pregnancies in African societies. Traditional methods include periodic abstinence, withdrawal, rhythm, breastfeeding, and coitus interruption. There is a limited data on traditional methods in Africa, but research indicates that younger women (aged 30 and below) rely more on traditional methods, mainly withdrawal and periodic abstinence, than older women (Bertrand et al. 1985). While it is true that modern contraceptives may sometimes fail, women themselves also contribute to contraceptive failure by not using them appropriately. Contraceptives play a major role in reducing unintended pregnancy in Africa, as Akintade (2010) showed: two-thirds of unintended pregnancies in developing countries occur among women who are not using any method of contraception. This means that the consistent and reliable use of modern contraceptives can successfully reduce the rate of unintended pregnancy.

2.5. Factors contributing to low contraceptive use

Family planning programmes are described as organized efforts to ensure that couples who want to limit their family sizes and space their children have access to contraceptive information and services and are encouraged to use them as needed (Tsui 2001). The main objective of family planning programmes in developing countries is to reduce child and maternal mortality mainly by changing the age at which women have children (Trussell and Pebley 1984). This is because at very young ages, women are not fully physiologically developed; hence many of them die. Many studies which have been conducted to review the sexual and reproductive life of young people in most African countries show that, even though young people are becoming sexually active at younger ages, contraceptive use has remained extremely low among them (Maharaj 2001; Meekers 1994). A range of factors influencing contraceptive use is discussed below.

2.5.1 Early age of sexual onset

Young people's sexual behaviour differs from one country to the other. Age at first sex can best describe the sexual behaviour of young people in a certain population. Statistics suggest that 100 million young people become sexually active every year worldwide (Anderson 1994

in Makatjane 2002). Age at first sex seems to be overlapping with the rate of sexual engagement among young people. That is, while there is a sharp decline of age at first sex among African youth, the frequency at which young women are engaging in sexual intercourse is increasing. This therefore contributes significantly to a high rate of unintended pregnancy in most African countries. Early sexual onset by young African men and women is found to be perpetuated by declining age at menarche, resulting in high rates of unintended and out-of-wedlock childbearing (Zabin and Kiragu 1998; Meekers 1994). Studies show that "rapid urbanization, industrialization, and social changes in developing countries have contributed to an increase rate of unintended pregnancy as they have weakened cultural links within extended families and between generations" (Olukoya et al. 2001, p140). This has also resulted in the breaking down of traditional social controls by elders over the sexual behaviour of adolescents (Meekers 1994). In Lesotho, average age at first sex is reported to be 15 (LDHS 2009).

Early sexual onset also contributes significantly to low contraceptive use. Studies show that having sex at an early age is often associated with unsafe sex because of lack of knowledge, lack of access to contraception, lack of self-discipline to negotiate safer sex while drunk or drugged and inadequate self- control to resist pressure (Akintade 2010). In most if not all African countries, contraceptive use increases with a woman's age and marital status. That is, young unmarried individuals are more vulnerable to unintended pregnancy because of their limited access to contraceptives. However, having limited access to contraception does not stop young people from engaging in sexual activities. Studies show that unprotected sex and non-monogamous sexual relationships are the major determinant of unintended pregnancy among young people in Lesotho (LHDS 2009). To make matters worse, young women engage in sexual relationships with older men with whom they cannot even negotiate safer sexual practices (Makatjane 2002). An imbalance of power in relationships often leads to negative reproductive health outcomes. It is indicated that in Lesotho, men are more dominant in relationships than women, and this puts women at higher risk of experiencing an unintended pregnancy (Tuoane et al. 2004). Luke (2003) in a study of age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa observed that engaging in sexual relations with older partners is the norm for adolescent girls in sub-Saharan Africa. Studies which have been done to explore young people's sexual behaviour,

however, show that it is difficult for young girls who engage in sexual relationships with older men to negotiate safer sexual methods for fear of the threat of physical violence, desertion, and economic hardships (Maharaj 2001; Akintade 2010).

In fact, it is now common for young women in sub-Saharan Africa to engage in certain types of sexual behaviour such as offering sex for money or having intercourse as a result of force or coercion (Gage 1998). Research indicates that young women from low income households are found to be more vulnerable to engaging in unsafe sexual practices of exchanging money for sex than those from wealthier families. As Zabin and Kiragu (1998) explained, adolescents with low socio-economic status experience eight times as much physical abuse and four times as much rape within relationships than adolescents with higher socio-economic status. Several factors influencing early sexual onset among young people are discussed below.

2.5.2 Urban - rural residence

There is no empirical evidence on the issue of urban-rural residence in relation to young people's sexual experiences. The influence of urban-rural residence differs from one society to the other. For example, urban residence has a positive effect on premarital sexual intercourse in Burundi, but a negative effect in Ghana and Togo (Meekers 1994). According to Makatjane (2002), the effect of rural-urban residence on premarital sexual experience is not significant. However, a study investigating the prevalence of premarital sex and childbearing in Lesotho found that sexual activity is 8% higher among never married women residing in urban areas than in rural areas. The study emphasizes that the norms of the society discouraging sex before marriage have been eroded more in urban areas than rural areas, and urban areas provide a favourable environment for experimenting with sex before marriage. Zabin and Kiragu (1998) **also** stipulated that the problem of premarital sexual activity is high among young people in urban areas, where increased independence, schooling and later age at marriage combine to break down patterns of premarital abstinence which once existed.

2.5.3 Education

Whether education promotes or inhibits early sexual experience among young people, it is still a controversial debate. Some researchers argue that sexual activity is low among women with little or no education compared with their educated counterparts (Makatjane 2002), while others argue that education promotes early sexual debut because it tends to remove young people from the supervision of traditional caretakers hence encouraging early sexual onset. For example, young people now obtain knowledge from books to challenge the wisdom of the older generation (Meekers 1994; Zabin and Kiragu 1998). Meekers (1994) emphasized that modern education and the school environment enables young people to interact more with partners of the opposite sex. This interaction may therefore promote early sexual onset. Mturi and Moerane (2001), however, do not find significant differences in sexual behaviour between women with higher education of secondary level or more and those with little or no education at all. However, they indicate that female education encourages women to avoid pregnancy in order to continue with their studies and they normally resort to abortions in cases where they fail to prevent pregnancy.

Zabin and Kiragu (1998), in their study of consequences of early motherhood in sub-Saharan Africa found that, in most countries, sexual activity is lower among young students than their unschooled contemporaries, except in Nigeria where premarital sexual activity is higher among women with secondary or post-secondary education than those with primary or no education at all. In Lesotho, sexual activity is reported to be higher among men with secondary education and above, than in their less educated counterparts, but for women the situation is vice-versa (LDHS 2009). Makatjane (2002) explains that the reason for a high rate of unplanned pregnancy in Lesotho is that formal education has caused erosion of certain practices that were traditionally meant to discourage premarital sex.

2.5.4 Contraceptives failure and fear of side effects

Every method of contraceptive has its limitations and strengths. There is some kind of unreliability inherent in different contraceptive methods, which contribute to unintended pregnancy. Grossman et al. (2010) stated that, although unintended pregnancy has multiple

determinants, contraceptive non use and method failure are both common, contributing significantly to the rate of unintended pregnancy. Studies show that approximately 28% of women taking contraceptives experience unintended pregnancy (Hubacher et al. 2008). For example, as they indicate, women starting oral contraceptives, injectables or implants may experience unintended pregnancy because of attrition. They also point out that of 1000 women using the injectable method of contraception, 109 may experience unintended pregnancy.

Male condom use is one contraceptive method which is reported to have a higher failure rate compared with other modern contraceptive methods. Studies show that 15% of women using this method of contraception in sub-Saharan Africa experience an unintended pregnancy (Hubacher et al. 2008). However, Hearst and Chen (2004) showed that this failure is owing to inconsistent use, low use among those at risk and negative interactions with other strategies. Maharaj and Cleland (2006) found that factors that contribute to inconsistent use of condoms include unanticipated opportunities for intercourse, romantic intensity, alcohol abuse and others. Hubacher et al. (2008) also emphasized that each contraceptive method has a typical-use failure rate which results in additional unintended pregnancies. If contraceptives are used consistently and appropriately they can provide more protection.

Besides contraceptive failure, women fear the negative side effects of various contraceptive methods. Health concerns are the most common reasons why women may choose not to use contraception, and this reduces the proportion of women who should be on contraception (Grossman et al. 2010; Oddens 1999). Castle (2003) indicated that contraceptive use is driven by health rather than by fertility limiting concerns. For example, because of prolonged bleeding when using injectables, women may fear using this contraception because their partners may seek sexual partners outside their families (Castle 2003). The author also states that after the use of injectables, a return of a woman's normal menstrual cycle may be delayed and this may bring fear of sterility to women using this method.

Pills also have negative effects that may cause many reproductive women to have a fear of using them; these include congenital heart defects, limb reduction deformities, and other major malformations (Harlap and Eldor 1980). Use of low-dose pills can also result in breakthrough bleeding and spotting, and sometimes can result in missed periods which, although not harmful, can be irritating (Castle 2003). Women's contraceptive choices are therefore strongly influenced by such perceptions of the physical and psychological effects of contraceptive methods (Oddens 1999). Castle (2003) however indicated that an important dimension in contraceptive decision making which is not clearly understood, is the role of perceived and actual side effects, particularly with regard to women's choice of hormonal versus other methods. This means that women themselves contribute to negative outcomes of contraceptives by not choosing the appropriate methods. The most commonly reported contraceptive side effects include weight loss, obesity, high blood pressure, anaemia, abnormal bleeding, hypertension, breast cancer, obstructed and prolonged labour, infertility and many infections (Zabin and Kiragu 1998; Gazinzi 2006; Grossman et al. 2010). In some cases women using contraceptives report that these affect their mood changes. Oddens (1999) also indicated that in a number of cases, condoms and natural family planning (NFP) are associated with feeling more tense, restless, and anxious, as well as less relaxed, and also with respect to oral contraceptives (OC), more women report experiencing irritability and depression.

2.5.5 Perception about the risk of pregnancy

Not much has been done to review young people's perception of risks of pregnancy. Many studies concentrate more on other reproductive issues among young people, and only little is known about whether young people engage in certain sexual behaviour being aware of the risks associated with such behaviour. According to Gage (1998, p154), "decisions to engage in unprotected sex are based on insufficient knowledge and distorted judgements of the risks of becoming pregnant and acquiring sexually transmitted diseases". Studies done in sub-Saharan Africa show that young woman usually have a low perception of the risk of pregnancy, and contraceptive use may only increase with previous experience of unintended pregnancy (Akintade 2010; Gatsinzi 2006). Gage (1998) and Mturi and Hennink (2005) also indicated that sometimes young women have perceptions that they are too young to become

pregnant; pregnancy does not occur on first sexual intercourse and the young women also base the probability of conceiving at a given time of the month on an incorrect knowledge of the fertile period. A study which was done by Zabin and Kiragu (1998) in Kenya found that young women are so ignorant that they even believe that they can avoid pregnancy by such measures as washing their genitals after intercourse, jumping up and down after sex, and having sex standing up. Some studies also indicate that mostly young women do not know that they can become pregnant even if they have sex only once (Gage 1998).

This low perception of risk of pregnancy increases young people's vulnerability to unintended pregnancies. Eaton et al. (2002) showed that high perceived risk of vulnerability and anxiety about personal risk is linked to greater intended and actual sexual behaviour change. Generally, young people are aware of the risk of unwanted pregnancy but there are also many real and perceived barriers to condom use and other contraceptive methods (Maharaj 2001; Akintade 2010). The low perception of risk of pregnancy is accelerated when young people do not fall pregnant after engaging in sexual contact.

2.5.6 Lack of accessibility and availability of contraceptives

Lapham and Mauldin (1985) define contraceptive prevalence as current use of a means of fertility control, including male and female sterilization, pills, injectables, intrauterine devices, condoms, spermicides, foams, and diaphragms, as well as traditional methods such as withdrawal, rhythm, and abstinence. Availability and accessibility of contraceptives are important issues which may be necessary to be explained prior to other determinants of fertility. This is because contraceptive prevalence and use rely mostly on accessibility and availability of such services, and in other countries inaccessibility to contraceptives is a major cause of unwanted pregnancy (Akintade 2010). As Lapham and Mauldin (1985) stated that it is important to consider availability and accessibility separately from contraceptive use, because cultural influences may strongly affect the use of contraceptives, even when they are readily and easily available. In Lesotho the availability of contraception is a serious problem, and besides the government's goal to increase contraceptive level to above 70% in order to reach replacement level in 2011, contraceptive prevalence is still very low (Tuoane et al.

2004). Studies show that various contraceptive methods in the country are very limited, and this contributes to low use, especially among young women (Tuoane et al. 2004). As the authors state, in Lesotho young women are also facing a huge challenge of being restricted about the choice of methods to use.

Accessing contraceptives is another problem in Lesotho. This is a challenge faced by all reproductive individuals (married and unmarried, rural and urban) and the situation becomes worse for unmarried, young women and men. Studies in Lesotho show that teenagers do not have easy access to family planning because they are afraid of being seen by adults when consulting these, and again, some contraceptive methods such as sterilization, pills, Norplant, injectables and IUCDs are not readily available to youngsters (Mturi and Moerane 2001). Another reason is that family planning service clinics and government hospitals in Lesotho are open on Mondays to Fridays only. It is therefore not easy for those working and for students to access services during weekends. Akintade (2010), in a study of awareness of contraception in the National University of Lesotho (NUL) observed that, about two thirds (69%) of participants can easily access family planning services. This limited access to family planning services is owing to the fact that the school clinic is closed on weekends when more students are free. The hours of family planning services in Lesotho are therefore not suitable for a large number of people. Tuoane et al. (2004) indicated that, in both rural and urban areas, those who are working complain that the hours at these facilities are not convenient, particularly because most sites are closed at lunch hour, and apart from that, family planning clinics are situated far away, and clients have to travel a long way in order to access the services.

The financial costs associated with contraception are a barrier to use. In the study of contraceptive use at NUL, Akintade (2010) found that money has been a hindrance to contraceptive use among many respondents. In Lesotho, the government subsidises family planning services. In government hospitals there is only a small amount (five rand) to be paid for family planning services. Even though the charges are very low, many people still cannot afford to pay for such services. Some women, especially from rural areas, report that it is

expensive for them to access contraceptives because they have to pay for transport costs, then for services (Tuoane et al. 2004).

2.5.7 Religion

Not much has been done to review a clear relationship between religion and contraceptive use, however, the existing literature shows a negative correlation between the two. That is, the stronger the religion the lower the use of contraceptives. For example, Akintade (2010), found that at NUL religion in 27.6% of people acts as a barrier to the use of modern contraceptives or family planning services. According to Gatsinzi (2006), most religions do not support contraceptive use and religious people fear that God will punish them for using contraceptives. In Lesotho, the most dominant religion is Christianity, with Catholics in the majority. The Catholic Church is known to be explicitly and consistently against family planning and abortion (Levinson 1998). Makatjane (2002) in a study of premarital sex and childbearing in Lesotho found that the Catholic Church was a positive influence on young people's sexual behaviour. For example, the study found that unmarried women of other religions are 1.3 times more likely to experience premarital birth than their Catholic counterparts. While religion is found to have a negative influence on contraceptive use, it is also important in influencing positive behavioural change among young people, especially if they abide by religious laws and rules.

2.5.8 Marital status

Research highlights that even though sexual activity before marriage is now more prevalent, attitudes towards responsible parenthood have not kept pace (Olukoya et al. 2001). In most African countries teenage sexual behaviour is being ignored by elders anticipating that unmarried adolescents should behave according to so-called norms and values of their societies, hence failure to communicate safer sexual practices, resulting in high prevalence of STIs and unintended pregnancy. The social norms concerning premarital sexual intercourse do not necessarily correspond with actual behaviour (Meekers 1994; Akintade 2010). Meekers (1994) indicates that even in the past and in societies that strongly oppose premarital sex, these norms are sometimes violated. Akintade (2010) and Olukoya et al. (2001)

emphasized that in most of sub-Saharan Africa, family planning services are designed mainly for married women and the social changes have usually not been accompanied by adequate increase in the provision of information on sexuality and reproductive health services for adolescents. The issue of unintended pregnancy which hinders fertility decline in Africa, however, is higher among unmarried teenagers and adolescents, and should be addressed predominantly within that group. In some countries health workers even display judgemental attitudes, (Akintade 2010; Nkambule 2009).

Little research has been done to view how unmarried individuals may make contraceptive choices while they are still single (Castle 2003). Marriage is one of the principal proximate determinants of fertility (Bongaarts 1982). Many studies indicate that the marriage rate among the female population plays a crucial role in that population's birth rates. Hinde (1998) also stated that in some populations fertility is mainly determined by the proportion of female population that is married. Caldwell and Caldwell (2002) also advocated that in sub-Saharan Africa men and adolescents cause shock if they go to family planning clinics, while adolescents are more often than not turned away. This behaviour of health workers may derive from the cultural view that women are not supposed to engage in sexual relationships before marriage. This issue of culture which denies teenagers access to modern family planning services plays a crucial role in teenage motherhood in South Africa. Caldwell and Caldwell (2002) emphasized that, in Africa there is a demand for contraception by adolescents of both sexes, but men and adolescents cause shock if they attend family planning clinics. Research also shows that there is usually a lack of communication between parents and their children about matters related to the reproductive health of adolescents, and this puts young women at risk of unplanned pregnancies.

2.6 Conclusion

Risky sexual behaviour and early sexual onset among young people are seen as the key influences on unintended pregnancy in Lesotho. Low contraceptive prevalence and use contributes to vulnerability of young people to unintended pregnancy and other negative reproductive health outcomes. There is a hope that if young people can change their risky

sexual behaviour unintended pregnancy will be reduced. Research done in the 1980s show that unintended pregnancy existed even in the past but there were only few if any intentions to abort (Lederman 1984). The literature that has been reviewed shows a direct relationship between contraceptive use and unintended pregnancy. That is, the greater the contraceptive prevalence and use, the fewer unintended pregnancies occur. The gap between contraceptive knowledge and use should also be closed. That is, better knowledge of contraceptives should match utilization of such services in order to avoid undesirable consequences of unintended pregnancies. This means that fertility decline in Lesotho will only be achieved by balancing contraceptive prevalence and uptake, suggesting that availability and accessibility of contraception should in part be accompanied by use of such methods. In general, this highlights that increasing availability and accessibility would have a smaller or no impact at all if there are still negative attitudes and distorted judgements hindering its use.

Contraceptive methods are meant to reduce the rate of neonatal deaths and maternal health problems. Research highlights that unintended pregnancy and early childbearing have an influence on other maternal problems experienced by reproductive women; to overcome this situation, there should be increased contraceptive prevalence and use (McCubbin et al. 1985). Trussell and Pebley (1984), looking at changes in reproductive behaviour also stipulated that infant mortality would fall substantially if childbearing were confined to the prime reproductive ages of 20-34. They also emphasized that, besides the provision of information on sexuality, adolescents need social assertiveness, decision making, communication, and vocational skills. This means that young people are the ones to change prevailing circumstances of unintended pregnancies by practising safer sexual methods, and parents, health workers and the whole community should also provide support and relevant sexual information to young people. Finally, it would be helpful for family planning providers to provide friendly services to every person, giving proper information about contraceptive use.

Exposure to family planning messages rises with level of education of women. As expected, the association between education and exposure to family planning messages is consistent with the existing literature. The same is true with wealth status; educated women, and those

from the richest households are almost 14 times more likely than women in the poorest households to read about family planning in a newspaper or magazine (Boserup 1985).

Chapter Three

Methodology

3.1 Introduction

As explained in chapter one, the overall objective of the study is to investigate factors influencing unintended pregnancies among young women and barriers to contraceptive use. This chapter describes the overall methodology and methods employed throughout the study. The study uses qualitative data drawn from in-depth interviews. This chapter starts by describing the research setting and design of the study. Validity and reliability of the study including limitations of the study are also highlighted. Lastly, it explains ethical measures which were followed to conduct a study.

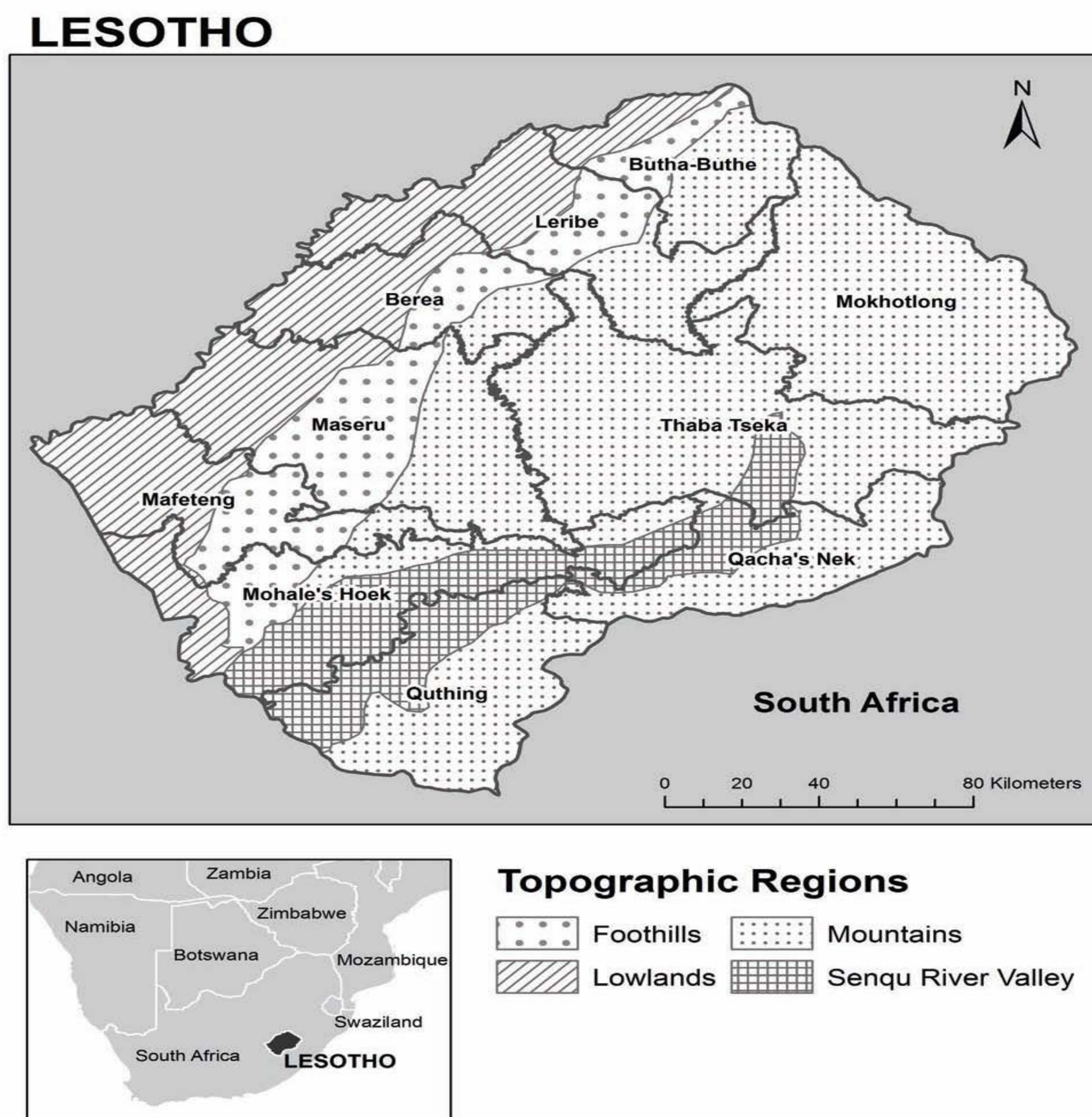
3.2 Research setting

Situated in the southern part of Africa, Lesotho is a small landlocked country sharing all its boundaries with South Africa. It is divided into ten administrative districts; Maseru (the capital city), Berea, Leribe, Butha-Buthe, Mokhotlong, Mafeteng, Mohale's hoek, Qacha's nek, Quthing and Thaba-Tseka. It occupies about 30 355 square kilometres and has a population of about 2.3 million (WHO 2009). It is a mountainous country divided into two residential areas, urban and rural, and further subdivided into four ecological zones: Lowlands, Foothills, Mountains, and Senqu River Valley (LDHS 2009). Surveys show that the country is predominantly rural with only 23% of the total population reported to be urban. Lesotho gained its independence on 4 October 1966 after having been a British protectorate for almost 100 years (LDHS 2009). The Basotho are a homogeneous group, identified by one language, Sesotho (Tuoane et al. 2004). There are two official languages in Lesotho: English and Sesotho. The dominant religion is Christianity, and the three main denominations are Catholic, Lesotho Evangelical and Anglican.

Lesotho is classified as one of the most economically poor countries. As mentioned before, the gross domestic product (GDP) of Lesotho is 9.013 billion. About 60% of the population

live below poverty line. The economy of the country depends mainly on subsistence farming, manufacturing and remittances from migrant labour based in South African mines (WHO 2009). Agriculture contributes about 7 per cent of the GDP, and manufacturing accounts for 17 per cent (LHDS 2009). More than half of the population of Lesotho is living below the poverty line, and this conforms in a broad term to the high unemployment rate which is prevailing in the country. Besides the economic crisis, Lesotho is facing many health problems, including HIV/AIDS, STIs and unintended pregnancy. Figure 3.1 below shows a geographical map of Lesotho.

Figure 3.1: Map of Lesotho



Source**:** LDHS **(**2009)

There are only two Universities in the country, Limpkokwing and National University of Lesotho (NUL). This study is carried out at the National University of Lesotho (NUL), being the principal and the largest university in the country. NUL is situated 34 kilometres southeast of Maseru (capital town of Lesotho). It currently accommodates 8700 students in a space of about 80 hectares. There are both undergraduate and a few postgraduate students (only 67) at NUL. There are 5338 female students and 3362 males, including 39 female and 28 male postgraduate students. The school has seven faculties; Education, Health Sciences, Humanities, Science and Technology, Agriculture and Faculty of Social Sciences. The seven faculties accommodate about 1243 students each on average. The students in the university are a complete socio-cultural representation of the population of Lesotho, because they are from different geographical parts of the country. One of the reasons for choosing to do the study in this university was that these students are socially and economically heterogeneous. University students are also used as a sample because better-educated people are expected and considered to be more knowledgeable about contraceptive use and other reproductive matters; on the contrary, however, there are misconceptions about family planning among female students at NUL, which often leads to a high rate of unintended pregnancy and induced abortion (Akintade 2010; Mturi and Moerane 2001). Unintended pregnancy is therefore by no means uncommon in this university.

3.3 Research design

In this study qualitative data was primarily obtained through in-depth interviews which were continued and administered during the months of July and August. The qualitative research method is much more fluid and flexible, and it is also superior in density of information to quantitative methods (Bryman 1984; Jick 1979). As a result, qualitative research explores objects in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Britten et al. 1995). In addressing the issue of unintended pregnancy, for example, qualitative methods are used to understand young people's views from the perspective of both women and men. It was also more appropriate and relevant to investigate their perceptions and attitudes towards contraceptives, which led to unintended pregnancies. The study also helped to explore their opinions and knowledge of contraceptive methods, as well as barriers to effective contraceptive use.

The in-depth interviews were used in order to encourage more informal stimulating involvement by respondents. This is a common method of data collection used in qualitative research. One of the main advantages of in-depth interview is that, when using this method, the researcher can elicit some non-verbal cues from the respondent, any discomfort, stress or problems that the respondent experiences (Sekaran 2003). This helps the researcher to adapt to changes that may be needed in order to reduce any discomfort or nervousness. The interviews were used to assess young people's perceptions of family planning, and their knowledge and attitudes towards contraception that lead to increased rate of unwanted pregnancy. Demographic characteristics of respondents were captured. The interviews consisted of two parts: the first and principal part was mainly qualitative information while the second part captured quantitative data. The quantitative data was used only to provide an outline of the sample characteristics. There were both unstructured and structured components to allow unrestricted flow of ideas from respondents. The interview guide was used to direct the discussion, but it did not restrain any additional materials that might arise. The guide covered awareness of risky sexual behaviour, perception of contraceptive use and factors that might be hindering contraceptive use among young people in Lesotho. There were follow up questions where necessary to foster clarification.

The interviews were tape-recorded with consent from the respondents, and respondents were assured of confidentiality and anonymity of the interview. The interviews took approximately thirty-five minutes each. The intention was to conduct the interviews anywhere inside the school premises, either outside or inside respondents' hostels, but most preferably the students' halls of residences were used, to avoid interference and maintain privacy of students; this also allowed freedom to share their thoughts and experiences without any intrusion. There were seven in-depth interviews conducted in July and eight in August 2011 and this constitutes fifteen in total. Ten interviews were with females and five with male students. The purpose was that, because females are the ones mostly affected by unintended pregnancy, a larger amount of data should therefore be captured from females. According to the centre for the study of Adolescence (2008), in Lesotho the few programmes which recognized the important role that men play, limited their focus to the promotion of condom use without making the link with broader issues of gender and sexuality and their impact on women's sexual and reproductive health. Owing to that, males' views on reproductive health

are always not adequately addressed, and it has been the target of this study to include male's views, because they similarly contribute directly to unintended pregnancy. It was therefore worth noting males' views on factors influencing unintended pregnancy as also their perceptions of contraceptive use. The interviews were carried out in English, but in cases where there was a need for clarifications to be made in Sesotho here was translation of the interviews.

3.4 Sampling technique

The goal of sampling in qualitative research is to select people who will most appropriately answer the research questions (Huston and Rowan 1998). The research used the sampling method, which looks at the conveniently available members of the population at the time and place of research. This method has the advantage of being the quickest, most convenient and cheapest sampling method among all other non-random sampling methods (Sekaran 2003). In this study, as explained previously, the sampling technique targeted young people, who are most affected by unintended pregnancy. They were assumed to be the ones most appropriate for giving answers to the question of unintended pregnancy, based on their experiences, attitudes and behaviour. In this context, to find more in-depth insights of the factors influencing unintended pregnancy, the researcher targeted women and men under the age of twenty-five who had either or not experienced unintended pregnancy. For those who have experienced an unintended pregnancy, it would be important to get more insights of their sexual behaviour before and after pregnancy. Consequently, for those who have not experienced an unintended pregnancy, the researcher hoped to assess the risk factors associated with their sexual behaviour. According to Pope et al. (2000, p114), "qualitative sampling strategies do not aim to identify a statistically representative set of respondents". Sampling technique is therefore not necessarily that influential on the results obtained, as the main focus is on the quality of data rather than the quantity.

3.5 Inclusion and exclusion criteria

For a person to be included in the sample, they had to be registered students of NUL, aged 18 to 24. Various authors define the period of adolescence in various ways. They consider it to occur between the ages of 15-19, 15-24, 10-19, or 10-24 (Dehne and Riedner 2001). The authors state that the terms 'young people', 'youth' and 'young adult' are therefore deemed better terms to encompass the very different experiences of individuals falling within these groups. This is a period of transition from childhood to adulthood, and often more reproductive health problems such as HIV/AIDS, STIs and unintended pregnancies are experienced at these age groups. It is at these ages that young people find themselves in the midst of many life-threatening health problems, which do not only affect them physically, but also interrupt their psychological, social, and emotional security (Preston-Whyte 1990). This is sometimes owing to the fact that they reach adulthood with little knowledge about reproductive health; the majority have no correct knowledge about sexually-transmitted infections, including HIV/AIDS, and risky sexual behaviour (WHO 2009). Being the most vulnerable groups, it is therefore important to elicit their views on the issue of unintended pregnancy and their perception about contraceptive use. Prior to the interviews, all respondents were asked their age. Anyone who was older than 24 years was not considered most vulnerable to an unintended pregnancy and therefore was not included in the study.

3.6 Ethical considerations

Ethical considerations are by far the most important procedure to be followed in a qualitative study; these considerations were thus duly met in this study. First of all the ethical clearance and approval from the university of KwaZulu-Natal was obtained. The researcher could then approach NUL management for permission to conduct a study in the school. She then randomly contacted and requested students to participate; thereafter any place suitable to respondents became the setting of the interview. The researcher started by going to the campus residence to recruit students. She started by introducing herself and requesting permission to conduct the research in their rooms or any place that ensured maximum privacy. Prior to conducting an interview, the researcher introduced herself, explaining the purpose of the study to the respondent. Anonymity of participants was taken into consideration and explained to them. The informed consent form was given to respondents to

read before they could proceed with the interviews and if they agreed to participate in the study they indicated their willingness by signing the informed consent form. It included the purpose of the study, the format of the interview, participants' right to participate voluntarily, their freedom to refuse to answer any question and to withdraw at any time. Using qualitative study means that the researcher incurs a particular responsibility to protect confidentiality (Britten et al. 1995). Participants were therefore assured of confidentiality and protection of their personal information. The respondents were also assured that the interviews would be kept strictly confidential and available only to members of the research team - the researcher and the supervisor. They were also assured of the privacy of the study and that their dignity was respected.

The interviews were conducted privately and individually, however, there were cases where respondents were in shared accommodation; declaring that they were comfortable and willing to respond in the presence of their roommate. The interview guide is attached to the appendix section.

3.7 Data analysis

The data was analyzed using thematic analysis. Huston and Rowan (1998, p2456) asserted that 'no matter what sampling technique is used or whether observational or interviewing methods have been undertaken, once the data has been collected, the qualitative researcher needs to "make sense" out of it all'. According to Buetow (2010), thematic analysis attempts to reveal core consistencies and meanings in a text by identifying and analysing themes, which are large, abstract categories of meaningful data segments. By appropriately analysing the data, the researcher may therefore identify new themes and develop hypotheses that may outline the basis of new theories. Runciman (2002) indicated that qualitative research often has observations which, when categorized, may suggest formulation of new theories and hypotheses, consequently, qualitative research usually entails examining the data to identify themes, which are then sorted into categories to form the basis of theories (Huston and Rowan 1998).

Using the model of sexual behaviour developed by Eaton et al. (2002) as an initial guide, the researcher identified themes within the data, using thematic analysis to identify any new themes which may suggest an adaptation to theories about barriers to effective contraception use that influence unplanned pregnancies. The analysis is based on the research questions stated in Chapter One, to determine factors influencing unintended pregnancy among young people. This analysis may, however, be subjective because the meaning assigned to responses may be influenced by the interpretation of the researcher, rather than by respondents' perceptions. To account for this, the researcher asked her supervisor to check the interpretations and analysis. The analysis of data was conducted manually.

3.8 Validity and reliability of the study

In a qualitative study, reliability is the concept of evaluating the quality of the study with the purpose of generating understanding (Golafshani 2003). The author also explains validity as one of the quality concepts in qualitative research which can be used to claim a study as part of proper research. Generally, validity and reliability measures whether the results of the study can be trusted to be truthful and prominent. In this study the reliability and validity was duly met through data collection methods and the types of instruments used. Using face-to-face interviews already has an added advantage of flexibility as the researcher can adapt the questions as necessary, clarify doubts and ensure that the responses are properly understood (Sekaran 2003). The research questions were administered using the interview guide which the researcher had developed with guidance from her supervisor. The questions were also reassessed by two other reviewers. Ambiguity was avoided in structuring the interviews and the language used met the level of understanding of the respondents.

3.9 Limitations of the study

Qualitative study does not yield the statistical or demographic results of the study. It was difficult therefore to capture the prevalence rate or incidences of unintended pregnancy in Lesotho. The research highlights that, qualitative and quantitative methods are complementary; no single method works perfectly on its own (Jick 1979). For more complete

and robust results there should be both qualitative and quantitative data, so that quantitative results can supplement the qualitative data, however, the relevance of research method depends on the topic under the study. It was therefore applicable in this study to use the qualitative method, because the intention was to investigate factors influencing the rate of unintended pregnancy, not to measure the prevailing rates of unintended pregnancy and contraceptive consumption.

Using in-depth interviews may be another limitation of this study as it can result in the researcher's influencing answers from the respondents. Researchers using this method often guide the conversation and may direct it to suit their own hypotheses rather than allowing a flow of ideas from their respondents. Sekaran (2003) also stipulated that respondents may feel uneasy about the anonymity of their responses when they interact face to face with the interviewer, however, the main aim of in-depth interviews is to encourage the interviewees to display their own understandings and perspectives (Britten et al. 1995). It is also necessary in cases where respondents need clarification of some questions. The researcher thus tried as much as possible to avoid influencing respondents' answers, but most importantly provided guidance in order for respondents to understand the questions the way they were intended to. Another limitation of the study lies with the sample size, which was relatively small and limited to students attending university. Because of the small sample size the results cannot be generalized to the whole population of Lesotho. Again, owing to the sensitivity of the topic, respondents may not feel free to expose their sexual behaviour for fear of stigmatization or social disapproval. This may have resulted in limited information from respondents.

3.10 Summary and discussion

Conducting this study was much easier than anticipated. Respondents neither declined nor withdrew from interviews. All people who were approached to take part in the interviews participated eagerly, and all questions were answered by the entire sample. The discussions were informal and stimulating, nevertheless directed by the interview guide for the sake of consistency. At the end of the interview, the researcher told the respondents how to get in

touch with her should they have questions on any matters arising from the discussion. It was somewhat difficult to tell whether a person was younger or older than twenty-five. In such cases the researcher had to establish whether the person qualified for the interview in terms of age before attempting any questions. The issue of tape recording was also a problem. Some respondents did not mind participating, however, they did not want to be tape recorded. In such cases the researcher had to return to the issue of confidentiality, reemphasizing it. Almost all students who were contacted were willing to participate, albeit at first very reluctantly. Respondents took part openly and nearly all of them answered all the questions.

This chapter sought to explain all the necessary steps followed in order to obtain the results of the study. In general, research shows that methodology flows from the research questions or hypotheses and informs readers about the who, what, when, where and how of the research conducted (Sekaran 2003; Jick 1979). The results of the study are enormously affected by the way the study was conducted. This chapter is therefore a very important one, which has a great influence on the results obtained from the study.

Chapter Four

Results

4.1 Introduction

This chapter outlines and details the findings from the qualitative data collected on factors influencing unintended pregnancy and barriers to contraceptive use, among young women in Lesotho. It starts by outlining demographic characteristics of respondents, followed by the analysis of young people's sexual behaviour. Next, the chapter considers perception of risk of pregnancy, and knowledge of, attitudes towards contraception and factors influencing use of contraception. The data from the in-depth interviews is also compared with the literature that was reviewed in Chapter Two. The results of the study were found to be largely consistent with the existing literature.

4.2 Demographic profile of the respondents

In total, fifteen interviews were conducted among young men and women. Females constituted about two-thirds of the total sample (ten out of fifteen), while males constituted one-third of the total sample (five out of fifteen). The in-depth interviews were used to gain more insight into the factors influencing unintended pregnancy. All respondents were single and below the age of 24 years. As indicated in the literature, young unmarried women are mostly affected by unintended pregnancy. The mean age of the sample was 20. The youngest respondent was 18 years and the oldest was 24 years. The dominant religion in Lesotho is Christianity: in this study all the respondents were Christians belonging to various denominational groups. The majority belonged to the Catholic denomination. All respondents in the study indicated that their churches do not support contraceptive use, especially among young, unmarried people, but the laws and regulations of the churches regarding contraception are not normally explicitly stated except by the Catholic Church. The Catholic Church explicitly forbids contraceptive use. Research shows that Catholics disapprove of contraception (Oye-Adeniran et al. 2006), stating that unnatural or artificial means of birth control is immoral and blameworthy, and is even considered as abortion. Because this is a

qualitative study involving a small sample, the findings cannot be generalized to the whole population.

4.3 Young people's sexual behaviour

There has been rapid change in young people's sexual behaviour, following a shift in socio-cultural norms and values guiding human actions. According to Taffa et al. (2004), increasing modernization and media exposure, along with a decline in the authority of parents and elders have undermined the societal and cultural rules that formerly controlled and informed adolescent sexuality. In previous decades, sex was believed to be solely practised by married people and all sexual and reproductive health matters were of concern only to them. Nowadays, however, it is apparent that unmarried people engage in sexual activities. An assessment of the extent and intensity of premarital sexual activity among teenagers is necessary to estimate the risk of teenage pregnancy in developing countries (Pillai and Barton 2004) The key changes that are often evident among young people include the frequency of their sexual activities, their number of sexual partners and the types of sexual relationships for example, cohabiting, which were not in existence in the past (Gupta and Mahy 2004). This changing sexual behaviour does not only expose young people to unplanned pregnancies and STIs, but poses a threat to their reproductive health. This study identified the three main risky behaviours leading to unintended pregnancies among young people: early sexual onset, multiple sexual partners and unsafe sexual practices.

4.3.1 Age at first sex

There is no proclaimed best way of defining what sex is; most people define it differently depending on their understanding of what sex involves. Sex is not limited to intercourse; not even limited, in fact, to genital activities (Klein 1998). Some people consider kissing passionately, touching or even talking about sex for pleasure as having sex. Other people may understand sex as only limited to penetration of sexual organs. In accordance with the above descriptions of what sex entails, for the purpose of this study sex is defined as vaginal intercourse.

There has been a constant decline in the ages at which young people engage in sexual intercourse over the past few decades. The median age of first sex among respondents in this study was 15, however, 4 out of 15 respondents initiated sex before age 15. Only 3 out of 15 respondents started engaging in sexual activities after age 18. Overall, 12 out of 15 respondents in this study were sexually active. The study found that among the sample males initiate sexual activities earlier than females. For example, the results of this study show that 3 out of 5 men had already initiated sex at age 15. Only one sexually-active male initiated sex after age 15, while the rest engaged in sexual activities earlier than that. For females, the majority begin sexual activities before the age 18. In this study, only one out of 15 had started engaging in sex at age 15. Overall, the median age at first sex among the sample was 14 for males and 17 for females. The youngest age at first sex for males was 10 and 12 for females. Only one respondent had had a child at the age of 16.

One of the major contributing factors to unintended pregnancy among young people is early sexual onset. As indicated above, it was found that young people initiate sexual activities as early as ten years of age. The study revealed that respondents in this study were sexually active and they were in casual or long-term sexual relationships, and most sexually active individuals initiated sex before the age of eighteen. Curiosity and peer pressure were the most common reasons for initiation of sexual activities among both men and women. The results of the study indicating early sexual initiation are consistent with existing literature. Lloyd (2005) indicated that in most cases females are likely to report sexual debut with a long-term, steady partner while males are far less likely to report this and much more likely to report that their first sexual experience was with a friend, casual contact, or sex worker. In this study most of male respondents reported that their first sexual experience was with a friend, while for females it was with a long-term partner. For many young women the first sexual act is voluntary. There was only one woman who reported that her first sexual encounter was forced.

Factors influencing early sexual onset

Peer pressure- This was found to be the main factor influencing early initiation of sexual intercourse among both males and females. Young people normally want to feel a sense of belonging or approval from the surrounding environment. Families and friends are the closest social groups that young people form bonds with and in turn influence their behaviour. (Wamoyi et al. 2011). In most African societies, however, young people's sexual and reproductive health (SRH) is mostly ignored by elders, and this is one of the factors which contribute most to negative reproductive health outcomes among young people. That is, young people's sexual lives are guided by what they or their friends think is right or wrong. This in turn influences them to act on what will be approved and endorsed by their peers. In this study, a large number (11 out of 12) of respondents who are sexually active reported that they started engaging in sex because their friends were already sexually active and they also felt eager to experience it. Young people also admit that they spend most of their time discussing sexual matters and experiences with their friends and this also increases their desire to initiate sexual activities. Both men and women reported experiencing peer pressure, though the study found that males were more susceptible to peer influence than their female counterparts. That is, men were found to be more likely than women to initiate sexual activities earlier, have multiple sexual partners and engage in unprotected sex.

> "*In boarding school I was staying with other guys who were always talking about sex showing how much they enjoyed it and all that, so I also wanted to experience that enjoyment"* (Male # 3)

> "*My friends were older guys and they were engaging in sex so I also wanted to feel older*" (Male # 2)

> "*We had been dating for four years and when we arrived here there was a lot of pressure from my boy friend, telling me at NUL everybody is doing it and after all we have been waiting for too long*" (Female # 6)

Media – the intention of the media might be to educate young people on safer sexual practices and protective measures to avoid unintended pregnancies and STIs, however, unexpected outcomes always occur as in many other intervention strategies. Some of the

information and advertisements shown on media may be sexually arousing and often viewed by young people as encouraging them to engage in sexual intercourse. For example, young people indicate that condom advertisements promote sex as they give them the assurance that they can engage in sexual activities without having the fear of negative outcomes. However, as soon as they initiate sexual activities they no longer use them consistently, hence they are at risk of pregnancy and STIs. Exposure to modern media has been documented by a range of research as one of the factors increasing desire to initiate sexual activities among young people (Pillai and Barton 2004; Taffa et al. 2004). In this study internet, television and radio are the most popular media from which young people derive their information. Respondents in the study indicated that there is a great deal of sexually explicit materials shown in the media, which seem to encourage participation in sexual activities. A large proportion of respondents reported that they first initiated sexual contact because of the influence of the media, for example, after watching sex movies on television and the internet and also listening to radio presentations about sexual matters.

> "*It is everywhere, everybody is talking about it, we hear about it on radio, we watch it on televisions and we see people rejoicing and we want to know what is really so exciting"* (Male #4)

> "*Sometimes it is because we see these things with our own eyes for example on television you find that people are practicing different styles of sex in public, and the next thing after watching that we want to try and experience it that way*" (Female # 7)

In general, the results of this study suggest that exposure to sexually-explicit material in the media may raise the likelihood of young people engaging in risky sexual behaviour.

Age – age was found to be another factor influencing sexual onset among respondents in this study. The findings of this study reveal that, at a certain age young people feel that they are grown up and can therefore engage in the same behaviour as adults. They often feel out of place among their peers if they have not started engaging in sex at a certain age. The common understanding is that, at least at the age of eighteen they should have initiated sexual activities. This explains why most of respondents in this study initiated sex before age 18. Some respondents reported that they started engaging in sex because they were old (more

than eighteen years old). For example, one female respondent indicated that she started initiating sexual activities because she had the reached the age of 19 years. Many respondents who initiated sex after age 18 believed that they had delayed sexual onset; this was recognized from the way they were answering the question about the age at which they started engaging in sex. The common response was "I was old'" then followed by the actual age at which they started engaging in sexual activities. In general the study found that by age 18 they considered themselves adults, feeling that they knew better; they often ended up engaging in risky sexual behaviour that could lead to STIs and pregnancy. One female respondent indicated that they sometimes engaged in sexual practices because they want to demonstrate their adult status and therefore to know most of the things their parents have been hiding from them. They feel that their adult status makes their parents feel jealous. For example, going out to parties at night and hanging out with friends most of the time makes their parents realize that they are sexually active.

4.3.2 Multiple sexual partners

Besides being sexually active at a young age, another factor that explains risky sexual behaviour that may leads to unintended pregnancy is the issue of multiple sexual partners. This study regarded having multiple sexual partners as engaging in sexual activities with more than one person concurrently. If there is no overlapping between sexual partners, that is, one sexual partner at a time, then the person was not considered to be having multiple sexual partners. Even though the issue of multiple sexual partners was more common among males, females also reported that they had more than one sexual partner at a time. All males in this study reported having more than one sexual partner concurrently. For females, **only 3 out of 10** indicated that they have more than one sexual partner. Female respondents had at most three sexual partners while male respondents had had more sexual partners. For male respondents, it was not easy to determine the number of sexual partners they have had, since they had long-term and short-term sexual partners, and this makes it difficult to verify the number of sexual partners they have had. In long-term relationships both men and women overall ascribe the most importance to warmth and trustworthiness in the prospective partner, while in short-term relationships warmth or trustworthiness play a less dominant role (Fletcher et al. 2004). In this study, long-term sexual partners were usually referred to as

girlfriends and boyfriends for males and female respondents respectively, while short-term partners were referred to as casual partners. Both males and females in the study reported having had multiple sexual partners.

Casual sex – as indicated above, young people view sex as a game and therefore tend to have many partners. This, as they refer to it, is called casual sex, meaning that there are no strings attached, it is just having fun. Permanent relationships require some social mores including the do's and don'ts; there are no such restrictions in casual sexual relationships. As they explain, sexual intercourse rarely ever happens with the same person. Normally it happens that a person has sex with one person and the next time a person feels like having sex, he or she goes to a different (new) person. Casual relationships are exclusively physical in their nature, while in permanent relationships there is some emotional attachment between partners. There is a very high risk of pregnancy and STIs associated with these kinds of relationships, because sexual activities happen spontaneously. That is, people had not planned to have or thought of having sex, they just find themselves engaging in sexual activity. It is therefore less likely that protective measures are used in spontaneous sexual encounters. Men were more likely to engage in sex with casual partners than women. Unexpectedly, this kind of behaviour was more prevalent among younger age groups (18 or below) than older ones.

> *"I have many sexual partners, but some we are just playing they are not my girl friends"* (Male # 2)
>
> *"Whenever I approach a girl I already know that I am not going to marry this girl, so I do my thing and move on"* (Male # 1)

There is growing evidence that many women have multiple sexual partners mainly for socio-economic purposes (Rwenge 2004; Preston-Whyte 1991). Some young people are entirely dependent on sexual partners for financial support. It is difficult in relationships where women obtain economic benefits to negotiate safer sexual practices, because of fear of losing their financial support from their partners. Besides economic reasons, women sustain many sexual partners to secure marriage. In many African societies, women gain respect and more recognition from the society if they are married, therefore young people grow up with a huge

desire to be married by a certain age. This normally places pressure on young people to have many partners in search of a long-term partner. Waite and Joyner (2001) assert that women search for signals of a long-term commitment and are dissatisfied in its absence, whereas men make long-term commitment unimportant for their satisfaction; they are more concerned about physical orientation towards sex. By having many sexual partners, women believe that at least one of the partners will become long-term or even a husband. This increases girls' vulnerability to unintended pregnancy; they engage in such relationships mainly to impress men, proving that they are worthy of marriage, hence they do not insist on safer sexual practices. In fact this study found that boys use girls as their sexual tools to satisfy their own desires. Some of the stated reasons for having multiple sexual partners among respondents in this study are discussed below.

Lack of trust – Young people are found to be so highly sexually active that they find it hard to deny themselves any sexual relationship. Many respondents who reported having multiple sexual partners indicated that they were keeping more than one sexual partner for the purpose of security. They feel that if they lose one sexual partner then at least there will be other partners that that they are left with. In other words they do not feel that they can lose one partner and remain without any sexual relationship. This attitude contributes to a high rate of pregnancies because young people are less likely to use protective means in all sexual encounters. Risk therefore increases with the increase in the number of sexual partners. In general, the study found that the desire to keep many sexual partners is influenced by a lack of trust between partners. Female respondents were more likely than male respondents to be distrustful of their sexual partners. They feel that if they have more than one partner they will not be alone. They seemed to be afraid of being without a partner.

> "*Men are not trustworthy, you do not have to put all your trust on one person because you will be so hurt and disappointed when you realise he has been fooling you"* (Female # 3)

> "*you cannot trust men at all...it is better that even if you love a person you still have the other one so that in case the other one dump you, you do not die from pain*" (Female # 5)

"*I do not want to trust someone who is not my wife that she will not leave me, so in case she leaves I will still remain with others"* (Male # 2)

Staying far from permanent sexual partners – unlike in the past when sex before marriage was taboo in many African societies, nowadays it is rare to find unmarried people remaining chaste. As indicated, young people feel so compelled to engage in sexual activities that they find it hard to stay far away from their so-called permanent sexual partners. Some respondents in the study confessed that they have more sexual partners because their permanent partners are far away and they cannot refrain from sex for a long time. This means that they form other temporary sexual relationships specifically to engage in sexual contact. As indicated earlier, this type of relationship is mostly associated with unprotected sex happening spontaneously. This in turn leads to unplanned pregnancies. Staying far from a permanent sexual partner was, among male respondents, a very commonly cited reason for having multiple sexual partners, whereas this reason was cited less by females.

"*Actually my girlfriend is far and we only meet during school holidays so I am keeping the other one for the time being"* (Male # 3)

"*No it's because they are not all here, the other ones we meet after a long time, may be during school holidays, so I have these ones here so that for the time being I still have some girl friends*" (Male # 4)

"*My permanent boyfriend is at home, so here I am just having fun I am not that serious with this one*" (Female # 5)

Peer pressure was also cited as one of the forces encouraging multiple sexual partnerships among young people. There is a substantial difference in peer influence between men and women. Males usually improve their social status by having many sexual partners. In this study male respondents indicated that their friends normally mock them if they have only one sexual partner: to gain respect from peers they normally decide to have more sexual partners. In fact, males who do not boast about sexual experiences such as having many sexual partners or practising unsafe sex are subject to scrutiny from others. One male respondent

indicated that he used to compete with his friends about his sexual conquests with a number of girlfriends and the man with the greatest number of girlfriends is perceived as a real man. Conversely for females, there is usually some kind of negative feedback from peers for those who have more than one sexual partner. This explains why studies suggest that males tend to over-report sexual behaviour while women will choose to under- report it.

Poverty was also found to be a contributing factor to having multiple sexual partners among young people. The influence of poverty on risky sexual behaviour was consistent with the existing literature. Coerced sex and exchange of sex for money are found to be strongly associated with risky sexual practices. Rwenge (2004) indicated that young people from poor families may engage in sexual activity with multiple partners or casual partners or agree to have sex without a condom in order to satisfy their material needs. Respondents in the study stressed that some young people depend entirely on their sexual partners for financial support. As in the literature which indicated that unintended pregnancy is higher among women with lower socio-economic status, this study also found that young women from poor families are more vulnerable to unintended pregnancies than those from higher socio-economic families. Many respondents admitted that some young women engage in many sexual relationships mainly to gain financial support from their partners.

> "*Sometimes we look at advantages and disadvantages like if you have a boy friend and he has money as young people we think that is the end and we sacrifice whatever it takes to please our partners so that they will also support us financially, so we end up engaging in such risky behaviours*" (Female # 9)
>
> "*Some girls only survive on financial support from their boyfriends and they end up thinking that it is the only way they can survive, so they tend to have many sexual partners so that they obtain financial support from them*" (Male # 5)

It becomes very difficult therefore for young women to negotiate safer sexual practices in this type of relationship owing to a fear of losing financial support. This indicates that some young women, who engage in sex solely for their economic survival, are more vulnerable to negative reproductive health outcomes. Numerous studies have documented the powerful

influence of poverty on young people's risky sexual behaviour. In general it is indicated that there is a close relationship between women's socio-economic status and vulnerability to pregnancies and other life-threatening sexual outcomes (Zabin and Kiragu 1998; Gage 1998; Lloyd 2005).

4.3.3 Practicing unsafe sex

Unsafe sex was regarded in this study as engaging in any sexual contact without the use of any modern method of contraceptives to prevent pregnancy. Young people are at the stage where they enjoy experimenting and discovering new things, so they spend most of the time with their peers sharing their life experiences. It was discovered in this study that some young people engage in unprotected sex mainly to explore sex, using no means of protection. One female respondent confessed that she once engaged in unprotected sex just to explore the feeling, because her friends were always talking about how enjoyable it is to have sex without a condom. Most of sexually active respondents in this study reported having engaged in unprotected sex at least once. This explains why a large number of respondents have been exposed to the risk of unintended pregnancy. The study revealed that almost all sexually active individuals have been either at risk of falling pregnant (for females) or of impregnating someone (for males). Most of the reported risks came about through deliberately engaging in unsafe sex; some were owing to failure of a contraceptive method. In one case exposure to pregnancy was a direct result of rape.

The main method used among young people is the male condom; although respondents also claim that it usually breaks, putting them at risk of pregnancy. Another commonly used method is the emergency pill, which is normally used in the case of condom breakage or after deliberately engaging in unprotected sex. The oral pill was also another method used; although only one female respondent reported having used this method. Unprotected sex was found to be more associated with first sexual contact and also 'casual sexual encounters'. In most cases the first sexual contact was associated with more risk because most young people reported having not used any protection method either because of lack of knowledge or lack

of access to contraceptive methods. Casual sex perpetuates risky sexual behaviour among young people because it is not planned and prepared for.

> *"Actually it was not even my girlfriend, it was just a girl and we were in the same room so we just wanted to experience it"* (Male # 1)
>
> "*If a girl visits me I am not sure whether we are going to have sex, so I cannot always have condoms next to me, but the problem is when they are far I cannot also stand up and get them from wherever they are*" (Male # 3)

Male partner resistance- In the sample, most male respondents who were sexually active reported that they did not use any protective method in their first sexual contact, while only a few females reported not having used any method in their first sexual counter. The majority of both males and females reported not using any contraceptive methods consistently. The study revealed that girls engage in risky sexual behaviour mostly when influenced by male partners. One male respondent indicated that most of the time girls want to feel loved; in such cases they put themselves at risk in trying to maintain their relationships. In the majority of cases women fear disapproval by male partners, hence they resort to silence. Most of the girls who have been exposed to the risk of pregnancy also reported that they engage in unprotected sex because their boyfriends do not like condoms. In order to maintain peace and harmony in a relationship they defer to the partner by not using them.

> "*I think it is because of our boyfriends. Like you will hear them saying that they do not want wrapped sweet, something like that*" (Female # 8)
>
> "*Every time I talk about a condom with my boy friend I start a fight, so some times I just do things that I know they are not healthy for me just to avoid that*" (Female # 4)

On the other hand, however, men do not consider themselves as perpetuators of risky sexual behaviour. They blame females, arguing that girls are always submissive and do not insist on protection, therefore they (men) take control of the sexual encounter; they dictate the conditions under which the act occurs. According to one male respondent, once girls change their submissive behaviour and start exercising their ability to negotiate safer sex, they will

be able to protect themselves, however, they claim girls remain passive and silent in the relationships, thus putting themselves at risk of pregnancy.

> *"I have realised girls are very weak and you can do whatever. Like, if I want to have sex without a condom I can just do it. I have realised I am always the one who control myself because I fear STIs"* (Male # 4)
>
> *"Actually because many of the contraceptives are used by girls, they refuse complain that they are painful and some of them are not reliable and all that"* (Male # 2)
>
> *"It starts with a person herself; she is the first barrier because when I say we should not use a condom she says yes"* (Male # 4)
>
> *"Sometimes I do not t even say let us not use a condom, I just continue engaging in sex without using it and she does not say anything"* (Male # 2)

A number of studies show that there is a great deal of resistance towards contraceptive use among young people. The study which was done by Maharaj (2001) illustrates that men are more likely to complain that condoms interrupt sexual activity, cause discomfort, and ruin the excitement of flesh to flesh contact. Male respondents in this study also demonstrated some negative attitudes towards condom use. The common response for not using condoms was that they cause some discomfort and make sex less enjoyable, so this discourages them from using them. Some complained that it makes sex tasteless.

> *"It is like getting in inside the room every day knowing exactly that you are going to eat cabbage"* (Male # 3)
>
> *"It is like watching people having sex may be on television, you do not feel like you are the one doing it. You just feel like you want to do it, but you have not started"* (Male # 2)
>
> *"Sometimes we just get tired of eating wrapped sweet"* (Male # 1)

The main findings of this study in relation to partner resistance is that men do not want to use condoms themselves, but they also do not like girls using other contraceptive methods such

as pills or injections. One of the most common reasons for expressing negative attitudes to other method of contraceptives is the fear that they will engage in sexual activities without the risk of pregnancy, so as they argue contraceptives encourage women to engage in commercial sex work. This idea of was also supported by female respondents.

> *"Actually if you are young and unmarried, and if you are my girlfriend and you are using contraceptives, you will find that our relationship will no longer be interesting, Just because you are using contraceptives I know you are going to sleep with me, sleep with that one just because you know you are not going to have a child"* (Male # 2)

> *"You know girls fear pregnancy more than STIs. If a girl is on contraceptives obviously she can sleep around knowing that she is not at the risk of pregnancy"* (Male # 5)

> *"Usually when you are using contraceptives our boyfriends think you are doing it for someone else not for them alone"* (Female # 2)

Inter-generational relationships- As the literature indicated in Chapter Two, young people, especially females, engage in sexual relationships with older men with whom they find it difficult to negotiate safer sexual practices. Luke (2003) argued that the major motivation for young girls engaging in sexual relationships with older men is financial benefit. The findings of this study revealed that in all sexual relationships, males were older than females and the former were more dominant in deciding when and how to have sex. The age gap that existed between sexual partners was about seven years. The age differences were however not that great, as most girls were in sexual relationships with men who were only two years older or less. The study thus did not find any effect on unsafe sex that might be brought about by age differences in the relationship. It is expected that the risk of unprotected sex increases as the age difference between partners rises. The results of this study however suggest that in most cases there was no age gap between sexual partners.

Alcohol and drug abuse - Young people are likely to engage in risky behaviour as they are eager to experiment with new things. Alcohol and drug abuse are some of the key factors involved in the risk taking behaviour of young people contributing to unplanned pregnancies. WHO (2009) states that there has been a generally high alcohol intake among young people in sub-Saharan countries, which normally contributes to the risk of pregnancies and STIs. Respondents in this study also stressed the issue of alcohol and drug abuse as the leading causes of unprotected sex. Most of the risk-taking behaviour among young people takes place after consuming alcohol or other substances. Many studies on unintended pregnancies show that alcohol and drugs are the major contributing factors to unintended pregnancy and STIs among young people (Temple and Leigh 1992). This study also revealed that most unprotected sex among young people happens when they are drunk. Respondents in the study acknowledged that when they are drunk their sexual behaviour changes and this is mostly when they engage in unprotected sex**.**

> *"The day I made Tumelo (the child's name) I remember very well that I was drunk, otherwise I would not have sex with that guy"* (Female #3)
>
> *"Sometimes when we are drunk things just happen, like you find yourself having unprotected sex with someone who is not even your girlfriend"* (Male # 1)

Numerous studies have documented the powerful influence of alcohol on risky sexual behaviour among young people. Temple and Leigh (1992) assert that alcohol has more influence on sexual decision making among young people because they are developmentally not equipped to make contraceptive decisions, and they are not influenced by personal control and judgment. In this study, most respondents who reported having been at the risk of unintended pregnancy indicated that they were under the influence of alcohol.

4.4. Awareness of contraceptives among young people

In this study, knowledge of contraceptives was explored by asking respondents about the number and types of contraceptive methods. It was found that knowledge of contraceptives is universal among young people. Awareness of contraceptives varied according to age and

gender. Female respondents demonstrated a greater awareness of contraceptives than male respondents, as most of them knew about five or more modern contraceptive methods. Increased awareness of contraceptive methods among females is important for increasing women's choice of methods to use. The most known method is the condom, followed by pills, injections, and the loop. The least known method is sterilization. Almost all respondents knew about condoms (specifically male condoms) even if they had never used this. Knowledge of injections and pills is also very high, especially among urban females. Contraceptive awareness was found to increase with the age of respondents. Most respondents who knew five or more modern contraceptives were over the age of 18.

Awareness of a source of supply for contraceptives is expected to increase accessibility to different methods. In Lesotho, the most common sources of contraceptive supply are health centres, government hospitals, private medical facilities and Lesotho Planned Parenthood Association (LPPA). Other sources include private hospitals, family planning clinics, community-based care centres, pharmacies and even shops. Knowledge of a source of supply is found to be high among young people, because a large number of respondents had knowledge of at least one source of supply of contraceptives. Because young people have the fear of being recognized for using contraceptives, the most preferred source of supply for them is supermarkets, although only male condoms may be obtained there. They argue that they are less likely to be recognized and to encounter judgements about contraceptive use. Another source of supply preferred by young people is pharmacies, which normally supply oral pills and emergency contraception. The study however revealed that, despite this high level of awareness of a source of supply among young people, there are still some young people who do not know where to access contraceptives.

> *"Oh, I do not even know where they are found these contraceptives, I have had people talking about LPPA but I do not even know where it is"* (Female # *8*)
>
> "*I know contraceptives are available in hospitals and clinics, but the problem is where do I go when I get there, do I keep the same queue with other patients going to see a doctor or what?"* (Female # 4)

Young people's reproductive health is usually ignored in many African societies which consider sex a taboo subject. When entering their reproductive years, young people are therefore normally faced with the challenge of dealing with changes happening in their reproductive systems on their own. Preston-Whyte (1991) asserted that, in need of information, young people turn to their peers for guidance, or obtain information from magazines, books, articles and videos. Not all the information from those sources is correct and useful, however, hence young people retain false information which normally leads them to negative sexual outcomes. The dominant sources of contraceptive information among respondents were schools and friends. All the males in this study indicated that they do not discuss contraceptives with their parents; the majority of respondents in the study, except for a few females, indicated that they do not discuss sexual issues with their parents. When asked about the kind of information they discuss with their parents, these are some of the responses they gave.

> "*She tells me that old, married people can use them"* (Female # 10)
>
> *"She encourages me once I am involved in sexual relationships I should use them"* (Female # 1)
>
> "*We sometimes talk but we do not go into details, they just tell me I should avoid sex*" (Female # 5)
>
> "*They just tell me should I have a child then I am out of their home*" (Female #2)
>
> "*She does not either say I should or should not use them, she just talks about them and tells me what their purposes are*" (Female # 6)

As indicated in the quotes, most of the information given by parents is not well understood by young people. Even those who report that their parents talk to them, often find that they are lectured by their parents about the consequences of falling pregnant. Many respondents who do not discuss contraceptive use with their parents indicated that their parents do not discuss sexual matters with them because they believe that their children are sexually naive. In general, one major reason why parents do not discuss contraceptives with their children is that they still believe their children are not engaging in sex. Again, as already stated that sex

is still considered a taboo in many African societies, it was found in this study that parents are shy to talk to their children about sexual matters.

Young female respondents from urban areas were found to be most likely to talk with their parents about contraceptives. In this study, all respondents from rural areas reported that they cannot discuss sexual matters with their parents. There is growing evidence that connectedness or love, material support, behavioural control or monitoring, and parent-child communication are positively associated with reduced levels of risk-taking behaviour among young people (Biddlecom et al. 2009). The findings of this study also revealed that the quality of parent or guardian-youth relationships significantly decreases the chances of risky sexual behaviour. Respondents demonstrated a huge desire for guidance from parents, indicating that they sometimes indulge in risky practices because of lack of guidance from older people. They believe that guidance from parents may help postpone sexual initiation and promote safer sexual practices. This study therefore does not support the argument that discussing sexual issues with children promotes sexual activities among young people. All respondents have used at least one method of contraceptive (most commonly male condom), regardless of whether they had discussed sexual matters with their parents or not. The majority of respondents who reported media as their other source of information are more likely to be from urban areas.

As indicated earlier, friends are the major sources of contraceptive information among young people in Lesotho, and it is worth noting that most of the information from peers is not correct. This means unintended pregnancy and other reproductive health problems still remain a problem among young people, and requires attention from the older generation. It becomes important that parents acknowledge that their children are sexually active. Myths and misconceptions about contraceptives abound, circulating around young people. The most common myths include that contraceptives cause a woman's infertility at a later stage in life; they cause certain diseases; they destroy a person's body and even lead to death at some point. Some of the myths and misconceptions that young people obtain from their friends are stated below:

"You do not have to use these things they are dangerous to your body, they cause cancer, they cause this and that, and sometimes they result in death" (Female # 4)

"Others will say that you will be too fat and lose your figure and others tell you you will never have children" (Female # 9)

It is assumed that health providers are an important source of information about contraceptives. This study found, however, that only a few respondents have ever received contraceptive information from health care providers. Most respondents indicated that they have never received any kind of information about contraceptives from health care providers, except for a few individuals who for the most part were from urban areas. Some respondents, especially those who mentioned family planning providers as their sources of information, indicated that the last time they heard about contraceptives they were at primary school. Young people indicated that the information they receive from health care providers encourages them to use contraceptives and teaches them how the various methods are being used. This often reduces the likelihood of unprotected sex among young people.

4.5 Contraceptive use among young people

Contraceptive use was explored in this study by asking respondents whether they had ever used or were currently using any modern contraceptive method. Because of a high level of awareness of contraceptive methods among respondents, it was anticipated that contraceptive use would also be high. However, the results of this study show that knowledge of contraceptives does not necessarily influence their use among respondents. Few (3) respondents reported having never used any method. The common reason for not using was that they were not sexually active and therefore had no need to use contraceptives. A large proportion of both males and females reported having used at least one method of modern contraceptives, usually the male condom. Two female respondents indicated that they stopped using contraceptives because they were not currently sexually active. Overall, 10 out of 15 respondents were currently using contraceptive methods.

Looking at the results stated above it may be assumed that contraceptive use is high among respondents, however, it is worth noting that those who are currently using contraceptives are not using them consistently. Contraceptive use does not differ between males and females. The study found that almost all sexually active respondents have used at least one contraceptive method, however, only three methods were used: male condom, oral pills and emergency contraception. The study found that the male condom is by far the most common method used by all those who are sexually active. It is, however, not used consistently, which explains why a large number of respondents have been at risk of pregnancy. Some of the reasons for inconsistent use of contraceptive are stated below:

> "*You find that sometimes you feel like having sex and you do not have them, and again they are boring*" (Male # 2)

> "*...sometimes condoms will be somewhere there in the cabinet so at the time I want to have sex I find it very far to go there and get them*" (Male # 3)

The quotes show that even with an increase in the accessibility of condoms, young people have more reasons for not using them.

Many studies concentrate on inconsistent and irregular use of a condom as a source of unintended pregnancy among young women. Research therefore tends to ignore the correlation between condom use and use of other forms of contraceptives. The findings of this study revealed that in most cases where other contraceptive methods are involved, the condom is less likely to be used. This to some extent perpetuates the risk of pregnancy among young women. For example, respondents who knew about emergency contraceptives were less likely to use condoms, indicating that whenever they engage in unprotected sex at least they know where to obtain the emergency pill. The study thus found that because of knowledge and access to the emergency contraceptive pill young people are not very conscious about taking other protective measures; hence some respondents boldly indicated that should anything go wrong again and again, they knew what to do. Respondents who reported having used more than one contraceptive method were most often from urban areas.

4.6 Barriers to contraceptive use

Contraceptive use depends highly on individual's perceptions, which are also influenced by other factors coming from the external world. Low contraceptive use among young women results from various socio-economic and socio-cultural factors. Lapham and Mauldin (1985) assert that family planning programmes are carried out within a variety of social and economic contexts, and their effects coincide with those of other influences on contraceptive use and fertility. Young people's decisions to use contraceptives are therefore influenced by a variety of social, economic and other factors which will be discussed below. Many respondents in this study acknowledge that contraceptive use among young unmarried people was not bad behaviour, although they do not like using them for some reasons which will be discussed below. However, some still consider contraception as unacceptable for young unmarried people, because they believe that family planning programmes are designed mainly for married couples. For all those who indicated that contraceptives should not be encouraged among unmarried people, the common reason was that they are not married so they have no family to plan as the name 'family planning' suggests. The following factors are found to be hindering contraceptive use among young people:

4.6.1 Awareness of risky sexual behaviour

While one would expect that awareness of risky behaviour will lead to an increase in the use of contraceptives, this was not the case among respondents in this study. The study revealed that young people are mostly aware of sexual practices that put them at risk of pregnancy. Such awareness would be anticipated to reduce risky sexual behaviour practices among young people, however, they continue engaging in such practices either because of peer pressure or other external forces. The literature which was reviewed in Chapter Two highlighted that young people's sexual behaviour usually changes after they have been exposed to the risk of pregnancy or after experiencing pregnancy. All sexually-active respondents in this study have been exposed to the risk of pregnancy either through deliberately engaging in unprotected sex or because of condom breakage. Respondents indicate that they normally worry about pregnancy after unprotected sexual activities, however, this does not influence them to use modern contraceptive methods to avoid the same anxiety in the future. This study therefore revealed that respondents' behaviour did not

change even after their worrying about exposure to the risk of pregnancy. One female respondent who had a child indicated that she did not use contraceptives even after experiencing unintended pregnancy. Even those who have been anxious about exposure to the risk of pregnancy still engage in an unprotected sex. Respondents who had been concerned about pregnancy show that the concern vanishes as soon as they realize that there is no pregnancy.

> *"Almost every month before my girlfriend gets her period I worry a lot and conclude that I will never engage in unprotected sex again, but as soon as she tells me she has her period I relax and start engaging in unprotected sex again"* (Male #4)

> *"No, like I said some of the things we just do them and we do not know why, because I was aware that I was at the risk"* (Female # 3)

When asked if they are aware of risky behaviour that leads to unintended pregnancy, respondents argued that most of the time they are aware of such behaviour, however, they continue to put themselves at risk. Many respondents in the study indicated that young people are normally aware of risky sexual behaviour that leads to pregnancies and STIs, but they choose to ignore it. Only a few believed that young people are not aware of risky sexual behaviour, indicating that they would not be engaging in such practices were they aware.

> "*Like I said, some things we do and we do not know why, because I was aware that I was at risk*" (Female # 3)

> "*We are aware but I don not know why we still engage in such behaviours. It is not like we do not know the consequences; we do but we choose to ignore them*" (Female # 7)

When asked if there are any aspects of the previous experience that could influence them to use modern contraceptives, the same respondents who have been at risk of pregnancy indicated that they have never come across any situation which could influence them to use modern contraceptives. For example, one female respondent indicated that she usually

experiences stress before her menstruation, but as soon as she realizes that she is not pregnant she starts engaging in unprotected sex again.

4.6.2 Availability and accessibility to contraceptives

Lack of availability and accessibility of contraceptives are generally regarded as major causes of unwanted pregnancies in many countries. There is still a problem of availability and accessibility of contraceptives among young people in Lesotho. They argue that the most accessible and available contraceptive method is the male condom, although its accessibility is still not at the peak. For example, at the National University of Lesotho, respondents indicated that condoms can only be found in male, and not in the female residences. In most African societies, masculinity is associated with high sexual performance while females are expected to remain passive on issues involving sexual matters. Putting condoms in male residences therefore creates the impression that they control sexual activities. In general, lack of availability and accessibility of contraceptive is caused by cultural norms that give men more social liberties to control sexual activities. For example, males determine when and how to have sex. This means they also determine whether any contraceptive method should be used or not. In some places, especially rural areas for example, married women have to ask their husbands for permission to use contraceptives. This makes it difficult for the unmarried to access contraceptives, because they do not have a back up allowing them to use contraceptives. In response to factors hindering accessibility to contraceptives these are some of the remarks they made:

> "*Unmarried people are not expected to be engaging in sexual activities, so they cannot go to the clinics and ask for contraceptives*" (Female # 8)

> "*Fear of going there and telling the nurses that you want contraceptives is one factor hindering accessibility*" (Female # 3)

> "*I have a fear of going there because people working there might know my mother and this is the fear for most of young people*" (Female # 7)

One other factor that hinders accessibility of contraceptives is lack of financial resources. In Lesotho the government subsidizes family planning services to meet the requirements of the population of low socio-economic status. Even in such cases where people have to pay a small amount, it is still very difficult for young people who are in a precarious financial position to access contraceptives. Some respondents confessed that they sometimes feel the need to use contraceptives, although they have a problem in accessing them because of lack of finance to pay for family planning services.

> *"It is usually expensive to pay for the types of condoms that we like from the shops because the free ones are normally not reliable, they break and they even smell badly*" (Female # 4)

> *"As young people we depend on our parents for financial support and we cannot use the little money that they give to always pay for contraceptives"* (Male # 1)

> *"The problem is that we use condoms but the ones we want are expensive, so sometimes we engage in unprotected sex because we cannot afford to pay for them"* (Male # 1)

This means that financial problems also limit young people's choice of contraceptive methods, thus they choose not to use any method if they cannot access the methods that they prefer. Adding to the fact that financial burdens influence low contraceptive use among young women, time factor is another barrier. In Lesotho family planning services are open Monday to Friday and closed on weekends and public holidays. A vast majority of young people are either in schools or universities and usually do not have time to access services during the week days. The few private family planning services which are normally open on weekends are very expensive to be accessed by young unmarried people who are still dependent on financial support from parents. One female respondent indicated that they really do not have enough time to go to family planning clinics, especially because they have to wait in long queues before they can obtain help.

> "*We are always at school and on weekends when we are free the clinic is closed, so we really do not have time*" (Female # 3)

"*Even if you go there during the weekdays may be when you have a slot, you do not get help in that short period of time either because of the long queue or shortage of staff*" (Female # 7)

"*Actually we do not have time to go and keep those long queues there*" (Female # 9)

Even though sometimes young people may be willing to attend family planning services, they have limited or no time to seek such services. Respondents in the study indicated that the campus-based clinic, like other public health facilities, also open during the weekdays when they are mostly busy with their studies. This means, even though family planning services are available within the university campus, students still lack access to such services. Again, the long queues in public health facilities also discourage them from accessing contraceptives, as they may find it time consuming and a waste of their time standing there for hours. For those contraceptives that are available over the counter, they have limited access because of financial problems.

4.6.3 Low perception of risk of pregnancy

Low perception of risk of pregnancy is another factor contributing to unintended pregnancy among young people. Most respondents in this study demonstrated low perception of risk of pregnancy. There is the notion that "frequent" sex leads to pregnancy. Respondents argue that "frequent" sex is a source of pregnancy. There was no clear definition of what this means but obviously from their response it was evident that they only believe a person is at risk of pregnancy if they engage in sexual intercourse with many sexual partners and also many times. A common belief is that young people are susceptible to pregnancy because they are more likely to engage in frequent sex. They feel that those who engage in sex less frequently are not at risk of pregnancy. Having one sexual partner, whether accompanied by safe sexual practices or not is thus a dominant perception, especially among young women that this is a way of avoiding pregnancy. That is, those who consider themselves as not engaging in frequent sex also perceive themselves as being at less or no risk of pregnancy.

"*I have only one sexual partner because I am scared of such things as pregnancies and diseases*" (Female # 4)

"*The amount and frequency of sex they engage in because you find that nowadays young people just sleep around with many people and the next thing they get pregnant*" (Female # 6)

The same respondents who perceived themselves to be at low risk of pregnancy because of having only one sexual partner were asked if they use protection consistently with their partners. The common response was that they do not use condoms in every sexual encounter. Some respondents indicated that sometimes they do not perceive themselves to be at the risk of pregnancy because some of their peers whom they know also engage in unprotected sex and do not get pregnant. Respondents even mentioned that young people only believe that unprotected sex leads to unintended pregnancy after they have experienced it.

4.6.4 Attitudes and beliefs about contraceptives

Young people's attitudes towards contraception were also explored in this study. Attitudes were divided into two groups: those who support contraceptive use among young people and those who do not. It was found that many respondents, both men and women demonstrated some negative attitudes towards contraceptive use. The common response among those who do not support contraceptive use among young people was that they promote promiscuous behaviour, because users will 'sleep around' without worrying about the risk of pregnancy. Others indicated that contraceptives are for married peoples to plan their families, not for unmarried people.

"*If a person is on contraceptives, they will engage in unprotected sex knowing that they will not get pregnant*" (Female # 1)

"I do not advice them, they are for married couples to plan their family, so for a boyfriend and a girlfriend what are they planning for!" (Female # 8)

On one hand those who support contraceptive use argue that contraception has benefits as it prevents unwanted pregnancy. It is not seen as bad to use, because young people enjoy sex and have fun without worrying about the risk of pregnancy.

> *"I think it's a good thing, it prevents pregnancies and allows the youth to have fun without worrying about pregnancy"* (Female # 2)

Attitudes towards contraceptives are also influenced by a number of factors, including the side effects. Many respondents who reported having used at least one method of contraception indicated that they sometimes experienced problems with the method. With male condoms the problem is that they sometimes break. Respondents who have used male condoms reported that they have experienced the problem of condom breakage, which put them at high risk of pregnancy. Those who have used the emergency pill also indicated that they sometimes vomit after taking the pill. This also leaves respondents with a huge concern of pregnancy because after vomiting they have less trust in the effectiveness of the pill. Despite the contraceptive side effects, this study found that there are many myths and misconceptions influencing young peoples' reluctant behaviour to use contraception. The most common side effects feared by young women include weight gain, infertility and STIs caused by reckless behaviour.

Fear of weight gain – young people need affection, placing heavy emphasis on physical appearance. Their identity and physical appearance matter to a very large extent, and even shapes their decisions to use or not to use contraceptives. The belief that contraceptives increase body size discourages them to use this method.

> *"They destroy our body, you become very fat and you loose your figure"* (Female 3)
>
> *"You see I am already very big, imagine how I would look like if I was using contraceptives!"* (Female # 6)

Besides the concern about physical characteristics, some respondents also claim that contraceptives affect their facial appearances and cause some menstrual irregularities.

> *"Sometimes you develop skin problems because of pills, your periods become irregular; they come and stop at any time, sometimes you just see some drops out of nowhere"* (Female # 8)

Fear of infertility – in many African societies, fertility is highly valued and supported by social norms. Failure to fall pregnant results in a woman being socially rejected by the community; she is also undermined in many spheres of life. It is because of these societal norms valuing childbearing for married women that even young people grow up very conscious of what might affect their fertility in the future. Many respondents in this study demonstrated a fear that contraceptives might cause infertility so that they cannot have children later in life.

> " *I think it's a good thing, but personally I have a fear of using them because I do not know what they might do to my body, I may end up not having children at all and again I do not know how safe they are when it comes to my health"* (Female 10)

> *"I also do not like them health wise because they break your chances of conceiving when you want a child, so that is why I advice them to people who already have children because even if their fertility is affected at least they already have children"* (Female # 8)

> "*They have after effects; sometimes you will not have children if you have used them for some years*" (Female # 1)

Fear of STIs – There has always been debate about the relationship between contraceptive use and STIs. Many people believe that contraception promotes promiscuous behaviour among users. This is a common belief among men, however, this study found that not only men consider contraceptives as encouraging promiscuity, women also subscribe to the issue that when using contraceptives their sexual behaviour will be reckless, hence result in STIs and other negative reproductive health consequences.

"*Encouraging contraceptive use among young people is likely to give them a green light and say go wherever and sleep around"* (Female # 5)

"*I do not want to use them, I do not want to be tempted to practice unsafe sex knowing that I will not fall pregnant while I forget that I will contact diseases*" (Female # 7)

"*We have seen it happening in our communities that girls using those things end up being prostitutes and eventually die from HIV/AIDS, because they engage in unprotected sex without the risk of pregnancy and have less concern about other reproductive health outcomes* " (Male # 5)

"*The problem is that young people tend to fear pregnancy and forget about STIs, so if they are on contraceptives then they will definitely engage in unprotected sex and end up having diseases. It is better when they still worry about pregnancy because they will not freely engage in unprotected sex*" (Female # 3)

A large number of respondents in the study indicated that increasing contraceptive use will probably result in an increase in sexually transmitted infections including HIV/AIDS. It is important also to note that besides myths and misconceptions discussed above, there are many other general fallacies around contraceptives which discourage young people from using them. These are some of the examples of fallacies that exist among young people:

No, I do not even think it is true that condoms sometimes burst I was told by one nurse that it is not true that condoms break, unless somebody bite it when trying to open the seal of the packet" (Female # 3)

"*I remember when I was at high school, there was a girl who used to tell us that her mother takes her for the injection, she was soft and her legs shining, having stretch marks and all that*" (Female 5)

It is worth noting that a large number of respondents in the study were aware that the process of reproduction involves both partners, and they feel that it is the responsibility of both men and women to prevent pregnancy. A large burden is put on women's shoulders with the most

commonly cited reason that they are the ones physiologically able to bear children and therefore they have to suffer the consequences.

> "*A woman should assume responsibility fro preventing pregnancy, it is her body, she is the one to carry the whole lump for nine months*" (Female # 2)

> " *It is a woman's responsibility because she is the one who will be the subject of ridicule...even her friends will laugh at her and as a man I will not even be there*" (Male # 4)

In other words the results of the study suggest that because women bear all the physical and emotional outcomes of pregnancy, they are the ones expected to take responsibility for preventing pregnancies.

4.6.5 Health care providers' attitudes

It is not uncommon to find that family planning providers' attitudes are one of the main contributing factors to the low rate of contraceptive use. As in much of sub-Saharan Africa, family planning providers in Lesotho also display judgemental and humiliating attitudes especially towards young unmarried women who come to clinics for contraceptives. In this study it was found that many young people decide not to use contraceptives because of fear of being humiliated and mocked by family planning providers; this prevents them from accessing contraceptives.

> *"You cannot go to the clinic and tell them you want contraceptives, they will tell you all sorts of embarrassing things"* (Female # 3)

> *"The way those women look at us! In many cases you find that they are judging us"* (Female # 2)

> *"Those old women you know when you go there they will be asking questions like; whose family are you planning?"*(Female # 6)

> *"We are not free to go there because those nurses are not friendly at all"* (Female # 9)

The services are also not male friendly. Since family planning issues have been considered a woman's responsibility, men find that they are not welcome when they seek family planning. Family planning providers thus display judgemental attitudes towards males who come to the centres for help.

> *"I once went to one pharmacy outside campus to get a pregnancy test for my girl friend, as soon as I mentioned that I came to buy a pregnancy test, the workers burst into laughter. I was so embarrassed and I concluded I will never go again"* (Male # 4)

4.6.6 Religion

Many previous studies have found that there is a negative correlation between religion and contraceptive use. In this study it was also found that religion influences negative attitudes towards contraceptives, and is the top cited reason against contraceptive use among young unmarried people. For example charismatic and Catholic denominations insisted on abstinence as the only way to avoid pregnancy among unmarried people and they do not take contraception as the other alternative. Contraceptive knowledge and use was also found to be lower among Catholics and charismatic Christians. This may be because the Roman Catholic Church strongly condemns contraceptive use, therefore young people already have attitudes which in turn lead to lack of awareness of and use of contraception. There are still some, however, who believe that even though abstinence is the most supported way of reducing the pregnancy rate among young people, if people cannot abstain then they may use contraceptives. In general, most respondents indicated that in terms of their religion contraceptives are not acceptable, however, looking at the high rate of unintended pregnancy in Lesotho respondents indicated that they would rather encourage contraceptive use among young people.

> "*Well using contraceptives is fine, but the best one is abstinence*" (Female #1)

> "*I am a Christian and my religion does not allow those things, but my view is that let us look at things that are happening, instead of bringing these children in to the world to kill them, so it is better for people not to conceive at all than to limit the killing of children through abortions and other stuff like that*" (Female # 7)

"*Basing myself on religion I do not think it is a good idea for a young unmarried girl or a young man to be going around with contraceptives because this tells me that at some point they are going to have sex, but leaving out the issue of religion aside I think contraceptives are the best option to prevent pregnancy*" (Male # 3)

4.6.7 Culture

Culture is about how people interpret action and what they think they are doing when they choose to act in a particular way (Preston-Whyte 1988). Cultural norms and values of societies normally influence attitudes and decision to use contraceptives. Norms and values of a society regarding premarital sex, however, ignore the changes in young people's sexual behaviour. This study revealed that attitudes towards contraceptive use mainly stem from cultural beliefs and practices. Young people demonstrated a fear of social stigma attached to the use of contraceptives by young unmarried women in Lesotho. The majority of respondents indicated that their culture still supports marital sex, and virginity among unmarried people is highly valued. It becomes difficult for young people thus to expose the fact that they are sexually active by going to family planning clinics. In Lesotho, cultural norms and values still associate family planning with marriage, ignoring sexually active, young people's reproductive needs. In general, respondents (mainly females) expressed a desire to use contraceptives, although hindered by their culture.

"*You start taking pills at seven in the morning and in the afternoon, people will look at you in a very judgemental way, so it is more like a shame that someone is taking contraceptives"* (Female # 2)

"It is difficult to go to the clinic to ask for contraceptives when you are not married, especially because those nurses might know your mother and tell her that you are sexually active!" (Female # 8)

"*I think it's a good thing because it prevents unintended pregnancy, but on the other hand it is a problem because culturally it is not acceptable"* (Female *# 3*)

"We know our culture does not allow premarital sex. I cannot even talk about contraceptives, so never mind going there and tell those old people I consider them as my parents, and tell them I want contraceptives!" (Female # 8)

In general, the results of this study suggest that cultural values and norms of societies limit access to contraceptives and may raise the possibility that young people will engage in risky sexual activities.

4.6.8 Urban-rural residence

Studies conducted in other parts of sub-Saharan Africa usually emphasize the difference in the level of contraceptive knowledge and use between rural and urban areas. In Lesotho, the strength of association between place of residence and contraceptive knowledge and use appears to be relatively small. The results of the LDHS (2009) showed that there is some relationship between place of residence and contraceptive prevalence and use in Lesotho, albeit not very significant. In this study the only variation was found in the level of knowledge, but not in the use of contraceptives. In general, young people have greater awareness of many contraceptive methods in urban areas than in rural areas. While one would expect knowledge of contraceptives to be reflected in their utilization, it was found that contraceptive use is low among young people in both urban and rural areas. Urban and rural areas were thus equally found to have less if any influence on contraceptive prevalence among young women in Lesotho.

4.7 Challenges young unmarried mothers are facing

Premarital fertility is still highly unacceptably in Lesotho. Almost all respondents in this study indicated that premarital childbearing is highly unacceptable in their communities. It was found that young women falling pregnant find themselves in the midst of problems. They encounter a great number of physical and emotional burdens. They are rejected by parents, friends or the community at large. In many situations, if a girl falls pregnant she is not accepted in the family; sometimes pregnant girls are even cast out of their homes. There is often little if any hope of a bright future among unmarried young mothers. Unintended

pregnancy is a shock on its own regardless of whether it happened in or outside marriage. For young women the situation becomes worse because instead of dealing with the traumatic physical changes brought about by pregnancy alone, they also have to face social stigma from their communities. One female respondent who had experienced an unintended pregnancy showed that she was badly treated by her parents when she fell pregnant, so much that at times she wished she were dead. Besides parental rejection, the other grave challenge carrying a huge emotional burden is rejection by the father of the child, friends and the whole community. Some of the challenges young mothers are facing are stated below:

> "*"even if they (parents) accept the pregnancy they no longer treat you like a child anymore, they believe you brought shame to their family"* (Female # 4)
>
> "*You cannot be seen walking around with someone who is pregnant, so as friends we also run away from those who get pregnant*" (Female # 1)
>
> *"First and foremost, the person needs education but cannot achieve it because she has to provide for the child, emotionally the person is not well because she is now a mother, the shame of having a child is just a life time burden"* (Female # 2)

The findings that pregnant girls bring shame and disgrace to the family suggest that even if the parents accept the pregnancy there is still some kind of discrimination felt by young mothers. They are no longer treated like other girls of their age either by their families, friends or the community.

Financial instability is another common challenge that young mothers face.. In the majority of cases young people who experience unintended pregnancy are not in a financial position to support their children. This is because pregnant young women are forced to drop out of school not usually completing their education either because they have to look for the financial means to support their children or because they are abandoned by their parents and cannot afford the school fees. Thus, the unintended pregnancy becomes an unbearable burden, especially on the side of young mothers who are often abandoned by their sexual partners, hence facing all the burdens on their own.

"*Obviously if you are a young mother you are not already working, so to support the child in our times is more expensive than in the past*" (Female #9)

"*Young mothers normally do not have cash to support their children and they are treated like slaves in their own homes*" (Male # 3)

"*The child needs financial support. Sometimes you have not even completed your own studies and you bring another mouth to feed when you are still dependent*" (Female # 7)

Lack of financial support for the children is brought about in most cases because as soon as they fall pregnant, young mothers are forced to leave school and this often marks the end of their education. Lack of education in turn leads to unemployment; as a result, they are unable financially to support their children.

Despite socio-economic consequences that young mothers are faced with, there are also many negative reproductive health outcomes encountered during or after the pregnancy. As a result of physiological and social immaturity and their lack of adequate prenatal care, young people experience more health risks associated with their pregnancies and childbearing than do older women (Zabin and Kiragu 1998). Respondents in this study also demonstrated an overwhelming concern about the reproductive health of young women indicating that young people normally do not accept their pregnancies at first and most of the time resort to abortions. Because abortion is illegal in Lesotho, pregnant women usually go for unsafe methods such as injecting herbs and other dangerous substances, using sharp objects; they employ many other methods that could jeopardise their health. Respondents mentioned that many young women in their communities die from the complications of unsafe abortions.

"*There were once two girls from my village who helped their friend perform an abortion by using a knife to cut through her stomach and tried to remove the baby*" (Female #1)

"*They end up killing themselves by drinking some poisonous herbs trying to perform abortions*" (Female # 4)

"*I heard some even drink things like spirit, stay soft and many other substances trying to perform abortions and they even die themselves*" (Male # 2)

These and other horrific incidents are happening at an alarming rate because young people's reproductive health is being ignored by elders in the society.

It is normally assumed that only women are affected by unintended pregnancy, however, Preston-Whyte (1991, studying fertility among African teenagers found that young men may also face the challenge of social stigmatization for impregnating a girl. This is not the case with young men in Lesotho. Some male respondents confessed that as soon as the girl falls pregnant they run away and deny the pregnancy, however, men still demonstrated the fear of making a girl pregnant and indicated that it gives them stress just to think that their sexual partner could be pregnant. This clearly shows that unintended pregnancy is a challenge to both young males and females, although women carry most of the burden.

4.8 Recommendations with regard to unintended pregnancy

There was also a question about what young people think could be done to reduce the rate of unintended pregnancy prevailing in the country. Parents' involvement was by far the most common recommendation made by respondents. They showed that guidance from parents would be the best way; they always indulge in risky sexual behaviour because they rely on advice from their peers who also lack enough and correct information. Both young men and women believed that parents have the responsibility to protect and prevent the rate of unintended pregnancy among young people, by giving them complete and correct information.

Another common suggestion was about the availability and accessibility of contraceptives. Some respondents expressed a great desire to use contraceptives, suggesting that other

contraceptive methods should be more available; these methods should be freely available. While it is true that the condom is the most available and accessible means of contraception, there is still the problem of accessibility of condoms. Respondents suggested that in order to increase condom use, these should be made available and accessible in many places where people will not be shy to obtain them, for example, in the toilets, bathrooms and other places which are considered private. About other contraceptive methods there is a great concern about age variations between family planning providers and clients in Lesotho. Respondents indicate that they would feel free to attend contraceptive clinics if family planning providers were young people who shared similar experiences as them and were less judgemental.

An association was noted between religion and sexual behaviour. Respondents in the study indicated that the strength of religion tended to reduce the likelihood of young people's engaging in sexual activities. One male respondent indicated that the best way to decrease the rate of unintended pregnancy is for young people to join church fellowship groups. This is because it is believed that religion tends to reduce risky behaviour such as drug abuse and sexual onset before marriage. Bahr et al. (1998) identified three ways in which involvement in religious organizations can reduce risky behaviour among young people: first, involvement in religion may provide a network of support and friendship that may insulate adolescents from opportunities to engage in drug abuse. Again, commitment to a religious organization may provide meaning to life that makes drug use less attractive, and lastly, the belief system of many religious organizations may reinforce personal beliefs against pre-marital intercourse.

Recreational activities would also help to decrease the rate of unintended pregnancy among young women. Many respondents in the study indicated that there are no recreational activities such as sporting or social clubs afforded by their communities where they could keep themselves busy. Young people thus find sexual practice a way to reduce boredom. In general the study found that there is a need for intervening recreational activities that will limit young people's exposure to sexual activities. For example, one male respondent indicated that he normally engages in sexual activities while at school because at home he

keeps himself busy playing basketball. This means recreational activities have the potential of reducing the rate of unintended pregnancy and other reproductive health problems.

Finally, the study found that knowledge of contraceptives should be improved among young people. They suggested that workshops training young people on issues surrounding risky sexual behaviour and lack of contraceptive use would be very helpful. In such teaching, there should be more emphasis on the consequences of risky sexual behaviour that leads to unintended pregnancy. That is, in addition to being told the positive aspects of safer sexual practices, young people should be told more about the negative consequences of not using them. Many respondents mentioned that it is the responsibility of both partners to prevent pregnancy, while only a few believed that it is one partner’s responsibility. For those who feel that it is a woman’s responsibility, the reason given was that women are the ones who carry the child for nine months. On the other hand, those who felt that it was a man’s responsibility, the reason was that in the African culture every child belongs to the father not the mother so for a father to reduce the burden of supporting many children, he should be the one responsible for preventing pregnancy.

4.9 Conclusion

This chapter detailed sexual experiences of young people in relation to their reproductive health. The key element in the analysis is that risky sexual behaviour and low contraceptive use predisposes young people to negative reproductive health outcomes. Young people mainly rely on the male condom as a means of preventing pregnancy, because other contraceptive methods are not easily accessed, and failure to use a condom usually results in unintended pregnancy. Even though studies are now concerned with young people’s reproductive health challenges, the trouble lies with measures taken to overcome such problems. There is no proclaimed perfect means of decreasing the prevalence rate of unintended pregnancy, however, the findings of the study suggest that there should be a shift in thinking that unmarried people are sexually naive and have no need for contraceptives, hence can be denied access. Even though the society greatly despises premarital childbearing, t it is happening at an alarming rate. Norms and values of societies regarding premarital sex

should therefore change with changing lifestyles. That is, current policies and intervention strategies on family planning and sexual behaviour should also be reviewed in line with the present situation of high unintended pregnancies among young people.

Chapter Five

Discussion and Conclusions

5.1 Introduction

The high level of unintended pregnancy among young people has been documented by several studies. The aim of this study was to investigate factors influencing unintended pregnancies among young women and barriers against effective contraceptive use. The paper directs attention to the effects of social and cultural influences on young people's decision to use modern contraceptives. This chapter has sought to give an interpretation of the results stated in the previous chapter. Young people's sexuality and pregnancy have been the subject of considerable research in Lesotho. Many studies have been conducted on factors influencing unintended pregnancy, concentrating more on low contraceptive prevalence and use among young people, however, analysis of barriers to contraception has been notably missing. In an effort to fill this gap, qualitative data was collected in the form of in-depth personal interviews to find out factors hindering use of contraception among young people. The most important contribution of this study is that it gives more insights into the main aspects influencing contraceptive use. The study also encourages one not only to think of knowledge of contraceptives among young people, but also about knowledge of sources of contraceptive supply. The researcher did not attempt an explanation for all the factors contributing to unintended pregnancy in the country; instead the focus has been more on young unmarried people, specifically university students. The results suggest that considering the rate of unintended pregnancy among young unmarried women in the country, it is clear that young people are actively involved in sexual activities. This study contributes to the growing body of research demonstrating the effects of low perception of risk of pregnancy among young people. We look at how the results answer the main research questions:

- Is unintended pregnancy a serious problem among young people?
- Are contraceptive methods accessible and available to young people?
- What factors hinder young people from accessing contraceptives?
- Are young people aware of sexual behaviour that influences unintended pregnancy?

According to the results of LDHS (2009), the median age at first sex among young people in Lesotho was 18.4, denoting a decrease from 18.7 years which was reported in 2004. Because of early sexual onset among young people in Lesotho, age at first birth also seems to be declining, and the percentage of those who have children is increasing over the years. According to LDHS (2009), 16% of women were already mothers at the age of 15. This is a slight increase from 15% which was reported in 2004 LDHS. The percentage increased rapidly (41%) for those who had a baby or were pregnant with their first child by age 19. Knowledge of contraceptives is found to be high among reproductive-age men and women in Lesotho. According to the LDHS (2009) 98% of men and women knew at least one method of modern contraceptive. The average number of methods known was 6.8 for women and 5.7 for men. Knowledge of contraception, however, does not correspond with the use thereof. There is typically low contraceptive use among men and women of reproductive age in Lesotho. According to the LDHS (2009), only 58% of sexually active unmarried women use modern contraceptives and 37% rely solely on male condoms.

Premarital sex is highly unacceptable in Lesotho and so is premarital childbearing. The findings of the study suggest that unintended pregnancy is a major problem, especially among young unmarried women in Lesotho. Compared with other sub-Saharan countries, premarital fertility is still unacceptable in Lesotho. Studies undertaken in other sub-Saharan African countries show that there is considerably greater tolerance of premarital fertility nowadays than in the previous years, for example, Jewkes et al. (2001) argued that in South Africa, premarital childbearing and impregnation are now socially accepted. It is unlikely that a young woman would be discriminated against for falling pregnant, for example, she is not forced to leave school for more than the academic year in which she gives birth (Preston-Whyte 1991). In Lesotho, the situation is different. There is little if any change in attitudes to premarital pregnancy. Mturi and Moerane (2001) indicated that, despite significant social change, Sesotho culture still generally opposes premarital pregnancies. Girls who fall pregnant before marriage often face a range of social challenges which affect their physical, social, and developmental wellbeing. Mats'ela (1999) cited in Phafoli et al. (2007) showed that in Lesotho, pregnancy out of wedlock is regarded as a disgrace to the girl as well as her parents, and this normally results in parents' ill-treating pregnant girls. Pregnant girls therefore have to bear the physical as well as emotional pressure of the pregnancy.

There has been a growing concern about young people's sexual behaviour in sub-Saharan Africa. Studies indicate that the traditional social controls on adolescent sexual behaviour have become less effective in most African countries, leading to high and increasing sexual activities (Meekers 1994). For the most part, the findings of this study put emphasis on the three main factors contributing to unintended pregnancy among young people: risky sexual behaviour, attitudes towards contraception and availability and accessibility of contraception. As indicated in Chapter One, the main hypotheses of Eaton's model of sexual behaviour are that young people are sexually active as opposed to abstaining or postponing sexual activities, they also have many sexual partners (either serially or concurrently) and they practise unsafe sex. These three hypotheses were fully supported by this study; the following discussion will relate the results of the study with the hypothesis stated by Eaton's model of sexual behaviour. Other determinants of fertility such as culture, religion and socio-economic status were also found to be influencing the rate of unintended pregnancy and other reproductive health matters.

The study revealed that many young girls experience sex because they are willing, not because they are forced. This is in contrast to a number of studies which suggests that the first sexual encounter is involuntary (Gage 1998). As indicated by the model of sexual behaviour developed by Eaton et al. (2002), at a personal level unsafe sexual behaviour is influenced by individual's knowledge and beliefs. The results of this study are consistent with this hypothesis. The findings suggest that young people are aware of risky sexual practices that lead to pregnancy, but because of negative attitudes and beliefs about contraception, they tend to practice unsafe sex. The theory explains that young people normally change their risky sexual behaviour after being exposed to or after experiencing unplanned pregnancies. This study, however, found that even after being exposed or after having experienced unintended pregnancy, young people still practise unsafe sex. At the interpersonal level, peer pressure, lack of access to contraceptives and male dominance in sexual relationships were found to be important in influencing unsafe sexual practices. Lastly, culture, religion, and poverty were also found to be influencing unsafe sexual practices, consistent with the findings of Eaton et al. (2002).

Research shows that the rapid socio-cultural transformation brought about by the rapid pace of modernization has influenced the probability of adolescent sex, and brought a change in young people's sexual experiences (Gupta and Mahy 2004; Pillai and Barton 2004). The most common features of sexual behaviour found in this study are early sexual onset, unprotected sex, and multiple sexual partners. Firstly, the results indicate that early sexual onset is usually associated with unprotected sex. The study revealed that young people strongly believe that at a certain age a person should have started engaging in sex, especially when they have reached eighteen years of age. Jewkes et al. (2001) argued that it is not the early sexual initiation that puts teenagers at risk of pregnancy, but other aspects of the circumstances in which sexual relationships are enacted, for example, forced sexual initiation. This study found that early sexual onset is mostly linked with the risky behaviour of unprotected sex, partly owing to lack of knowledge and the inability to negotiate safer sexual practices with their partner.

There are substantial gender differences in sexual behaviour which were found in this study. Generally, men reported higher sexual activity than their female counterparts. These included among other factors the number of sexual partners they have, which was normally accompanied by unsafe sex practices. In addition, males were found to be initiating sexual activities for example two years earlier than females. Disparities in sexual behaviour among males and females are usually brought about by cultural norms and values existing in societies. There is a dominant form of masculinity that influences the understanding of boys and men on how they have to act in order to be acceptable men (Frosh et al. 2002). Macia et al. (2011) found that multiple sexual partnerships are viewed by men as an expression of manhood; men who engage in multiple sexual partnerships are seen as demonstrating their manliness, which is generally associated with uncontrollable sexual desires. Cultural norms usually encourage risky sexual behaviour such as having more sexual partners, and unprotected sex among men. Sometimes women are also found to subscribe to dominant notions of masculinity, arguing that it is legitimate for men to have more than one sexual partner because there are more women than men in society (Macia et al. 2011). All sexually-active males in this study reported more than one sexual partner, while most females reported having one sexual partner. The latter might however under-report their sexual behaviour, therefore conclusions based on these findings have taken into consideration such behaviour.

Peer pressure was also found in this study as one of the contributing factors to risky sexual behaviour among young people. Since young people's reproductive and sexual behaviour are mostly ignored by elders, peers are the closest social group in which young people for the most part form social bonds. Peer influence is found to be high in schools and tertiary institutions. There is growing evidence that lack of monitoring in the university influences sexual onset (Meekers 1994; Makatjane 2002). Young people receive little or no information from their parents, thus it is equally plausible to argue that the most social support young people receive is from their peers. Rwenge (2004) indicated that the school promotes the interaction of young people of opposite sex in an environment that is not controlled by their family.

Alcohol and drug abuse are some of the contributing factors to unsafe sex among young people. There is a growing concern about alcohol consumption among young people in sub-Saharan countries. Research generally highlights that alcohol consumption is normally associated with risky sexual behaviour (Temple and Leigh 1992). The results of this study show that it is more likely for people to engage in unprotected sex if they are under the influence of alcohol. Respondents indicated that alcohol affects their ability to take responsible decisions and that they usually engage in unprotected sex when they are under the influence of alcohol. In most cases this is followed by a period of regret when they realise that they have engaged in unprotected sex. As expected, alcohol and drug abuse were more common among male than female respondents. Only a few female respondents reported alcohol intake, whereas more males reported that they take alcohol and mostly engage in unprotected sex when they are under the influence.

Poverty also contributes to unintended pregnancy among young women in Lesotho. Economic reasons were cited by most respondents as perpetuating risky sexual behaviour among young people. As stated earlier, Lesotho is classified among the most resource-poor countries in the sub-Saharan Africa. The study found that most girls fall pregnant because they engage in unprotected sex with richer men who promise to support them financially. There is no doubt that girls from poor families are more vulnerable to pregnancies because they normally engage in unprotected sex to sort out their financial problems. Rwenge (2004),

studying risky sexual behaviour among young people in Cameroon found that youth from poor families are significantly more likely than those from richer families to practice risky sexual behaviour such as casual sex. The question, however, is whether they really achieve their motives or not. It is clear from the results of the study that as soon as the girl falls pregnant, she is normally abandoned by the father of the child. The intention of sorting out financial problems thus ends up causing more financial burden. That is, girls who fall pregnant end up dropping out of school, fail to access better education, hence experience unemployment and remain poor. Unintended pregnancy thus results from poverty and vice-versa.

In general, the results of this study imply that even though young people sometimes engage in risky sexual behaviour in order to gain financial support, in most cases it contributes to their problems. A sizeable proportion of young women find themselves battling with consequences of the pregnancy with no support from their male partners. The results of this study show that married women may also experience unintended pregnancies, but the fact that they have a better financial and emotional support often means that the results of an unplanned pregnancy might not be serious and they might not acknowledge the pregnancy as unplanned.

The rising age of marriage may also encourage young people to experiment outside of wedlock, which in turn leads to unintended pregnancy. In Lesotho, age at first marriage has been increasing constantly, following the improvement in the socio-economic status of women. Today women are more eager to complete their education and in doing that they normally postpone other social commitments like marriage. It is assumed that when one is young at first marriage, it becomes easier for young people to postpone sexual onset until marriage. Today young people do not want to wait for marriage to begin sexual activities. Meekers (1994) argued that unmarried childbearing will continue to increase in sub-Saharan Africa, because the period at risk of premarital pregnancy will lengthen as women's age at marriage increases. Because of increasing premarital sex, the fertility rate cannot be measured in terms of married female population. In the past sex usually occurred within marriage, therefore the fertility rate could easily be predicted and measured in terms of the female

population married or living in unions, assuming that they are the ones who are mostly exposed to pregnancy.

Knowledge of contraceptives is universal among young people in Lesotho. Most respondents know about five methods of contraceptives on average. The most known methods are condoms, pills and injection and the least known methods are sterilization and spermicides. The study found, however, that most young people have little correct information about contraceptives, because of the myths and misconceptions surrounding the topic. The beliefs include the fear that contraceptives are dangerous to the body and harmful to the reproductive system. These beliefs always result in low contraceptive use among reproductive individuals. A study which was done in Nigeria on attitudes towards contraceptives indicates that there is a huge misperception about contraceptive safety; many people believe that contraceptives are dangerous and that chemicals in contraceptives can injure their reproductive systems (Okanlawon et al. 2010). Evidence in this study also indicates that even though young people may be willing to use contraceptives, the fear of the side effects hinders their desire to use them. Some of the most commonly cited side effects include weight gain, and STDs. Concern was also expressed that the use of contraceptives will promote reckless behaviour on the part of women. With the existence of such attitudes and beliefs, it becomes difficult for young people to admit to contraceptive use as an effective intervention strategy to reducing unintended pregnancy.

This study also found that peers are the main source of contraceptive information among young people. Unfortunately the information from peers is not always the correct. The study found many myths and misconceptions about contraceptives circulating among young people. This is in contrast to studies by Preston-Whyte (1990) and McCubbin et al. (1985) which found that peers not only influence each other negatively by manipulation and coercion, but they also influence each other in positive ways by offering advice, emotional support, and the opportunity to discuss conflicting points of view. The finding of this study also revealed that peers have a dual influence on young people's reproductive health. On one hand peers encourage negative sexual behaviour, while on the other hand they influence positive behaviour among the group. A considerable number of respondents in the study pointed out

that sometimes their peers advised them to use contraceptives, especially male condoms because this provides dual protection against both pregnancy and STIs.

The reasons for low contraceptive use among young people were also consistent with the existing literature. There is a range of socio-economic and cultural factors which are found to influence accessibility of contraception by young people in Lesotho. This study found that young people have a need for contraceptives yet they face challenges that limit their access. It is worth noting that in Lesotho, availability and accessibility to contraceptives is not only a problem to unmarried individuals, but is a challenge faced by all men and women of reproductive age in the country. Not surprisingly, young unmarried women face more challenges than married women. The most common sources of family planning in Lesotho include government hospitals and health centres, private medical facilities such as LPPA, and even shops. At the University of Lesotho, contraceptives can be accessed at the clinic which is situated on the University campus.

Because of socio-cultural norms of society which condemns premarital sex, young people face difficulties in accessing contraceptives. The findings of this study reveal that young people have a need for family planning services, although they have a fear of being recognized for using contraceptives. This is because society expects them to be sexually naive. This in turn impedes their freedom to access contraceptives because they feel less comfortable attending family planning services. Research indicates that even those who feel brave enough to attend family planning services are sometimes turned away. This is because at some reproductive health service centres unmarried adolescents can only access reproductive health services if they are accompanied by their parents (Tuoane et al. 2004). Respondents in the study demonstrated a huge desire for contraceptive use, however, as they indicated, it is not easy for them to go to the clinic and expose their sexual behaviour in front of older people.

Poverty is also found to be one of the factors hindering accessibility to contraceptives. Despite the government's effort to subsidize the costs of contraceptives, many people still cannot afford to pay the small amount being charged. In a study of provision of family

planning services in Lesotho, Tuoane et al. (2004) found that it is difficult for many women to access contraceptives because the costs are discouraging. The situation becomes worse for young unmarried women who are entirely dependent on financial support from their parents. The findings of this study revealed that the majority of young people who wanted to use contraceptives were not able to do so because of the charges they have to pay for services. Respondents also confessed that they cannot afford to use the small amount of money they receive from their parents to pay for family planning services. Adding to the costs charged for family planning services, respondents also mentioned that the hours of services are not convenient. In Lesotho, public service sectors are open Monday to Friday and closed on weekends. This is the time that most young people are in school or at work. It therefore becomes difficult for young people to access services, because the services which are open on weekends are normally private sectors with high charges. This study therefore finds contraceptive costs as potential barriers to accessing contraceptives among young people.

Family planning providers' attitudes have been documented by several studies as the major barrier to contraceptive access among young people. Unfortunately this problem has not been well documented in Lesotho. This study investigated and explored family planning providers' attitudes, primarily towards young unmarried people obtaining services. Consistent with other findings around the world, this study found that the quality of care has an effect on young people's decisions to use contraceptives. The social sanctions against premarital childbearing in African countries are usually reflected in providers' negative attitudes, poor treatment, or even refusal to supply contraceptives to young people (Gage 1998). The findings of this study reveals that family planning services in Lesotho are not youth-friendly. The great majority of respondents in the study indicated that they are often humiliated and sometimes turned away by health service providers. Adding to the judgemental attitudes by health providers, there is also a problem of limited choice of contraceptives in Lesotho. The most commonly available are condoms, oral pills and injections; this suggests that women have to choose from a limited number of available methods found in the centres. Because of the fear of negative attitudes by health care providers and limited choice in public health centres, young unmarried people prefer accessing available contraceptive methods over the counter. The problem, however, is that they require prescriptions and as indicated before, the costs are high in private sectors.

In many African societies, premarital sex is taboo and there is little or no discussion on this topic. Lesotho is no exception to this. Many studies show that young people are sexually active at a very young age, yet there is limited understanding of such behaviour from parents. Parents-children communication is regarded as an important factor influencing young people's reproductive health outcomes. This suggests that for young people to make informed decisions about contraceptive use there should be guidance from parents. As with other research conducted in sub-Saharan African countries, this study found that there is little if any communication between parents and their children about sexual and reproductive health matters. Even though respondents in the study expressed the desire to discuss reproductive matters with their parents, they also indicated that parents do not consider sexual matters a relevant subject for their children. Young people, however, believed that their decisions to use contraceptives would be influenced by the type of communication they have with their parents. Evidence from this study suggests that parents often do not discuss sexual matters with their children because of the widely-held belief that they are sexually naïve; discussing sexual matters with children is seen as promoting sexual activities. Tau (1994) cited in Mturi and Moerane (2001), however, argued that lack of communication between parents and children and that children are no longer as closely supervised have been significant factors allowing young Basotho girls and boys to experiment with sexual activities before marriage. This suggests that communication with parents can increase contraceptive prevalence among young people, hence lower the rate of unintended pregnancy in Lesotho.

There were also some limitations which were observed in this study and were taken into consideration. The sample was relatively small, and restricted to students attending a university. Factors influencing pregnancy among university students may differ considerably from those that influence pregnancy among young people in communities who are not at school. Again, the sample was randomly selected from those students staying in the residences, leaving out the ones staying off campus in rented accommodations. This might have an effect on the findings because environment itself affects people's sexual behaviour. There will undoubtedly be differences in sexual behaviour between students residing in university residences and those from off campus which were not included in this study. As a result there is a limited generalisability of the findings, which explains why the results of this study cannot be generalized to the whole population of young people in Lesotho.

Additionally, the in-depth personal interviews took place over a limited period of time, which may account for much missing material.

These limitations notwithstanding, the findings revealed a number of important factors which proffered some insight into the socio-economic and cultural economic factors influencing unintended pregnancy among young people. The most important contribution of this study is that it encourages one not only to think about low contraceptive use that leads to unintended pregnancy among young women in Lesotho; it also provides important foundations for understanding young people's sexual behaviour, and factors influencing such behaviour. Additionally, while many studies concentrate on knowledge of contraception as an important factor influencing use, this paper further highlighted the need for greater knowledge of a source of supply. It has long been discovered by many studies that knowledge of contraceptive methods is high among young people. This paper gives more insight into the attitudes and perceptions of young people towards contraception. The study generally highlights the need for contraceptive promotion and more specifically among young people in Lesotho. There is a need for further research investigating factors influencing young people to use contraceptives. An understanding of such factors will help in the realization of more powerful strategies to be employed in dealing with young people's reproductive lives.

5.2 Conclusions and recommendations

Besides difficulties in accessing contraceptives and other contributing factors to unintended pregnancies, there are several reasons why girls may have children at young ages. In some cases it is plausible to argue that the pregnancy is planned. Such motivations include proving their parity to male partners in anticipation of marriage or to create a bond that will ensure that male partners stay in the relationship. Gupta and Mahy (2004) argued that an early birth may be seen to secure marriage for a woman because it demonstrates her fecundity to the man's family and increases her social standing. Preston-Whyte (1990) also asserts that some girls fall pregnant in the hopes that the father of the child will marry them. As she indicates, sometimes the aim is not necessarily to trap the man, but to show their fertility and their desirability as wives. Although girls are engaging in unprotected sex mainly to please men, as

soon as they fall pregnant they are abandoned by the same people they were trying to please. It is a disappointment then when the father of the child rejects the pregnancy, and instead of a bond the pregnancy becomes a bridge to separation. This study found that one of the greatest emotional burdens young mothers are experiencing is their rejection by the father of their child. Young girls however still continue engaging in unprotected sex to please their partners even after seeing their peers experiencing the same problems. This study thus revealed that instead of creating a bond, the pregnancy creates a rift in the relationship. As soon as the girl falls pregnant the male partner denies this and leaves the relationship. In such situations even though the pregnancy was planned, the outcome was not; in this way the pregnancy has much in common with, unintended pregnancy.

Despite many intervention strategies being implemented to reduce the rate of unintended pregnancy in sub-Saharan Africa, young people always find excuses not to respond to them. For example, availability and accessibility of male condoms has greatly improved in Lesotho. In halls of residence for example, there are condoms in the toilets. Young people in avoiding their use claim that cheap condoms make them uncomfortable, have a bad smell, make sex less enjoyable and are usually the ones which break. Parents' control and monitoring was found to be more significant among young females than males. Girls who freely discuss sexual matters with their parents were found to be less vulnerable to risky sexual behaviour than those who do not. Even in cases where parents are free to talk about contraceptives with their children, they (children) find it strange because of the culture they have been exposed to.

Despite efforts made to reduce the fertility rate in Lesotho, TFR remains high because young people's sexuality and reproductive health needs are being ignored. With a sharp rise in sexual activities observed among young people, the rate of unintended pregnancy may grow further, hence implying an increase in the TFR as well. This study found that increasing contraceptive use among young people may avert early and unintended pregnancies. Improving availability and accessibility can be achieved through targeting all men and women of reproductive age. For a long time unmarried women and men were not the focus of family planning services. This is because the norms and values of societies highly oppose

premarital sexual activities, hence hindering unmarried people's freedom to express their sexual needs and adopt protective measures. Again, Lesotho is a patriarchal society where males are the key decision makers. Involving men in family planning will thus reduce the rate of reproductive health problems such as unintended pregnancies and STIs. So far, the only widely-available male method is the condom, which is not appropriately and consistently used because men sometimes complain that it decreases sexual pleasure.

In conclusion, this chapter discussed the findings from the qualitative data collected from university students in Lesotho. The results were linked and found to be largely consistent with the existing literature, both with young people's sexual behaviour that leads to unintended pregnancy and barriers to contraceptive use. The findings of this study also indicate that respondents are aware of the rate of unintended pregnancy in Lesotho, and that young people are the ones mostly affected. Even if unintended pregnancy exists among married people, the outcomes are not evident as with their unmarried counterparts. Again, even though premarital fertility has become more tolerated because it is happening at an alarming rate, this does not mean that it is acceptable. Parents still feel humiliated and belittled, but they cannot do anything about it. In the past pregnant girls were even expelled from their homes; parents now adapt easily to the situation. The study revealed that it has even come to a point especially in urban areas, where parents even encourage their children to perform abortion. This shows that regardless of societal norms and values discouraging premarital sex, parents are now aware that their children are sexually active. However, even with growing evidence of sexual activities among young people, many parents still deny the fact that their children are sexually active and therefore do not discuss sexual matters with them. Even in cases where parents awe willing to discuss sexual matters, children tend to ignore them because they believe they are not told the truth, parents always seeming to hide some information. Young people tend therefore to believe more what they hear from their peers than from their elders. Despite premarital fertility's current greater acceptability than in the past, the outcomes of unintended pregnancy do not change. In addition to effects on health, young people still bear the consequences of early pregnancy such as negative emotional, economic consequences. They also face a challenge of lack of education which often leads to unemployment, social stigma and discrimination.

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APPENDIX A: INTERVIEW GUIDE

DATE……………………………….

Personal Details

1. Age:
2. Gender ______

3. Marital status: □ Single □Married □ Separated □Divorced □other (please indicate)

4. Place of residence □ urban □ Rural

5. Religion…………………… Denomination……………………………..

Part one

6. Do you think unintended pregnancy is a problem in Lesotho? Who do you think is most affected by unintended pregnancy? Young? Married? Unmarried?

7. What do you think makes unintended pregnancy higher in this group?

8. What do you think is the major cause of unintended pregnancy among young women in Lesotho? What else? Could you tell me more about that?

9. How do communities view pregnancy among young unmarried women in Lesotho? Is it acceptable? Intolerable? Can you expand on that?

10. Please identify some of the disadvantages young mothers are facing in Lesotho?

11. Do you think young people are aware of risky behaviour that leads to unintended pregnancies? What makes you say that?

12. What are your views about contraceptive use among young people? Is it a good thing or a bad thing?

13. What is the purpose of contraception? Preventing? Delaying? Could you expand on that?

14. What are some of the barriers hindering contraceptive use among young women?

15. What alternative ways do you consider helpful in reducing the present rate of unintended pregnancy in Lesotho? Anything else?

16. What role do you think men should play in preventing pregnancy?

17. Who should assume responsibility for preventing pregnancy?

18. Have you ever been exposed to the risk of impregnating (for males) or falling pregnant (for females)? Please clarify your answer.

19. What aspects of your previous experience could influence you to use modern contraceptives? What exactly could influence you?

20. What do you think can encourage young people to use modern contraceptives?

21. How do young people interact with family planning providers in Lesotho? Frightened? Encouraged? Can you tell me more about that?

22. Where do you receive information about contraceptive use? Through parents? Health care providers? Peers, etc? What kind of information do you receive?

23. Have you ever used any method of modern contraceptives? Which one?

24. Are currently using any modern contraceptive method? Which one?

25. If you have never used any modern contraceptive method, can you explain why?

26. Have you experienced any problems with contraceptives? What are these?

27. Do you have any additional comments or suggestions about young people's sexual behaviour that might influence unintended pregnancy?

Part two

28. Can you remember how old you were when you first had sexual contact? Under what situation did you first engage in sexual contact? Forced? Persuaded? Please explain.

29. How old was your sexual partner?

30. Did you use any contraceptive method on your first sexual contact? Can you please explain?

31. How many sexual partners do you currently have? What influences you to have the number of sexual partners that you have?

32. How many methods of modern contraceptives do you know? Can you mention them please?

33. Do you have a child (or children)? Please mention how many you have. How old were you when you had your first child?