UNMARRIED FEMALE ADOLESCENTS' KNOWLEDGE AND ATTITUDES TOWARDS THE USE OF CONTRACEPTIVE SERVICES IN THE MASERU HEALTH SERVICE AREA

BY

'MATŠEPO LYDIA MOLETSANE

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SUPERVISOR: Ms. I. Venter

DECLARATION

I declare that the dissertation hereby submitted by me for the Master's Degree in Social Sciences (Nursing) at the University of the Free State is my own independent work and has not previously been submitted by me at another university. I further cede copyright of the dissertation in favour of the University of the Free State.

.....

'Matšepo Lydia Moletsane

June 2003

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BOS	Bureau of Statistics
CDC	Center for Disease Control
HIV	Human Immunodeficiency Virus
HSA	Health Service Area
MOHSW	Ministry of Health and Social Welfare
RCC	Roman Catholic Church
SADHS	South African Demographic and Health Survey
STDs	Sexually Transmitted Diseases
STI's	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
WHO	World Health Organization

ABSTRAK

Die reproduktiewe gesondheid van adolessente het 'n belangrike bron van kommer op die internasionale agenda geword. Die vermoë om adolessente se menings rakende die gebruik van voorbehoedmiddels en dienste in dié verband te verstaan, is van die uiterste belang om effektiewe strategieë te ontwikkel om ongewenste adolessente swangerskappe en aborsies – wat aan die toeneem in Lesotho is – te verstaan.

Die doel van die studie was om die kennis en gesindheid van ongetroude vroulike adolessente teenoor die gebruik van voorbehoeddienste te ondersoek en te beskryf. 'n Nie-eksperimentele ondersoekende en beskrywende metode is gebruik. 'n Opname metode waarvolgens data of gegewens ingewin is, is gebruik. Die relevante literatuur en fokusgroeponderhoude is gebruik om 'n vraelys saam te stel, wat die primêre navorsingstegniek was. Waarskynlikheidstoetsing met 'n proporsionele verteenwoordiging is gebruik om 'n steekproef van 969 respondente tussen 13 en 21 jaar uit 29 hoërskole in die stedelike en landelike gebiede van die Maseru Gesondheidsdiensarea te selekteer. Al die data wat versamel is, is op 'n nominale beskrywende vlak ontleed.

Die bevindinge van die studie en die gevolgtrekkings waartoe gekom is, het daarop gedui dat daar, onvoldoende kennis van reproduktiewe gesondheid en kontraseptiewe metodes is; wanopvattinge; 'n gebrek aan kennis rakende kontraseptiewe dienste; teenstrydige opvattinge en houdings teenoor die gebruik van kontraseptiewe middels; 'n gebrek aan adolessent-vriendelike dienste; 'n teenstrydigheid tussen seksuele aktiwiteite en die gebruik van kontraseptiewe middels; en ondergebruik van kontraseptiewe middels en kontraseptiewe dienste.

Gebaseer op bogenoemde, is aanbevelinge gemaak dat adolessente bemagtig behoort te word met kennis rakende kontraseptiewe middels en reproduktiewe gesondheid; wanopvattinge behoort reggestel te word; kontraseptiewe dienste moet geadverteer word; en adolessent-vriendelike dienste moet geskep word om sodoende die gebruik van kontraseptiewe middels en kontraseptiewe dienste te verbeter. In die laaste plek is dit beklemtoon dat verdere navorsing noodsaaklik is.

ABSTRACT

Adolescent reproductive health has become a major concern on the international agenda. Understanding adolescents' views about the use of contraceptives and contraceptive services is critical in developing effective strategies to prevent unwanted adolescent pregnancies and abortions that are on the increase in Lesotho.

The purpose of the study was to explore and describe the knowledge and attitudes of unmarried female adolescents towards the use of contraceptive services. A non-experimental exploratory and descriptive design was used. A survey method was used to gather data. The relevant literature and focus group interviews were used to compile a questionnaire, which was the primary research technique. Probability sampling with a proportional representation was used to select a sample of 969 respondents between 13 and 21 years from 29 high schools in the rural and urban areas of the Maseru Health Service Area. All the data collected were analysed on a nominal descriptive level.

The findings of the study and the conclusions reached showed that there is inadequate knowledge of reproductive health and contraceptives; misconceptions; lack of knowledge regarding contraceptive services; contradicting attitudes towards the use of contraceptives; lack of adolescent-friendly services; a discrepancy between sexual activity and the use of contraceptives; and under-utilization of contraceptives and contraceptive services.

Based on the above, recommendations were made that adolescents should be empowered with knowledge regarding contraceptives and reproductive health; misconceptions should be corrected; contraceptive services should be advertised; and adolescent-friendly services created, thereby improving the utilization of contraceptives and contraceptive services. In the last place the need for further research was emphasized.

CHAPTER 1

Introduction and problem statement

1.1 BACKGROUND INFORMATION

1.1.1 Geography

Lesotho, with a land area of approximately 33,355 square kilometres, is situated in the southern region of Africa and is completely surrounded by the Republic of South Africa. It is referred to as the Kingdom in the Sky because of its high altitude which is in excess of 1,500 metres above sea level. It is divided into four geographical zones, namely the Lowlands, the Foothills, the Senqu River Valley and the Mountains, which cover about 59% of the land surface. The country is further sub-divided into 10 administrative districts and Maseru is the capital (Bureau of Statistics [BOS]/United Nations Population Fund [UNFPA], 2000:7; Lesotho Tourist Board, 2000:4).

1.1.2 Population

According to the last population census undertaken in 1996 the total population was recorded as 1,960,069 with an annual growth rate of 2% and it was projected to reach 2,1 million in 2001. Young children under the age of 15 years account for 43.1% of the total population while adults aged 65 years and above make up 3.4% resulting in a broad based population pyramid. Females outnumber males by 51% to 49% (BOS/UNFPA, 2000:22).

People migrate from rural to urban areas mainly for educational and employment purposes. Females are chiefly involved in internal migration, while labour migration to South Africa is predominantly undertaken by men who are mostly absorbed in the mining industry (BOS/UNFPA, 2000:48).

1.1.3 Education

Education may be seen as an indicator of the level of development of a country, hence the government of Lesotho adopted an educational development policy to provide basic education to all its citizens. According to the 1996 census, the overall literacy rate was 78% with males at 70% and females at 85%. From this data it is obvious that the female population is more educated than their male counterparts. The girls, however, drop out of school due to factors such as teenage pregnancy and marriage (Ministry of Health and Social Welfare [MOHSW], 1993:3; BOS/UNFPA, 2000:36).

1.1.4 Economy

The country's economic structure is divided among agriculture, labour exporting and external funds. Although agriculture is considered the backbone of the country, the growth potential of this sub-sector is however limited due to the scarcity of arable land, adverse weather conditions and serious soil erosion. Lesotho has a limited resource base and water is the only major natural resource which is currently being developed through the Lesotho Highlands Water Project (BOS/UNFPA, 1996:46).

1.2 THE HEALTH CARE SYSTEM IN LESOTHO

The health care system in Lesotho is at four levels, namely the central level, the Health Service Area (HSA) level, the clinic/health centre level and the community level. The MOHSW has the primary responsibility for the development of policies, strategies and health care programmes. In 1979, the Lesotho government adopted Primary Health Care as the approach to achieve the social objective of Health For All by the year 2000 in line with the Alma Ata Declaration (MOHSW, 1993:3; MOHSW, 2000:6).

According to the MOHSW (2000:6), the health care delivery system is based on the HSA model which entails the division of the country into 18 HSAs based around a hospital. Each HSA constitutes a geographic boundary to which a catchment population is ascribed and a hospital is considered the highest referral unit within the HSA. The 19th HSA is the Lesotho Flying Doctors Services, based in Maseru, and responsible for 12 clinics in the inaccessible mountain areas using light aircraft.

Each HSA is responsible for the supervision of all health centres within its particular catchment area, regardless of ownership. The ownership of the health facilities in Lesotho falls into three categories: 52% belong to the government, while 48% are run by the member churches of the Christian Health Association of Lesotho and private organizations (MOHSW, 2000:6; Motaung, 2001:4).

1.3 STUDY CONTEXT: MASERU HSA

The Maseru HSA is the largest in the country and falls directly under the Queen Elizabeth II Hospital, the biggest and main referral hospital countrywide. Compared to other HSAs, it has more health centres (31) to supervise with many villages to manage (Maieane, 1998:5; MOHSW, 2001:1) (see Figure 1.1).

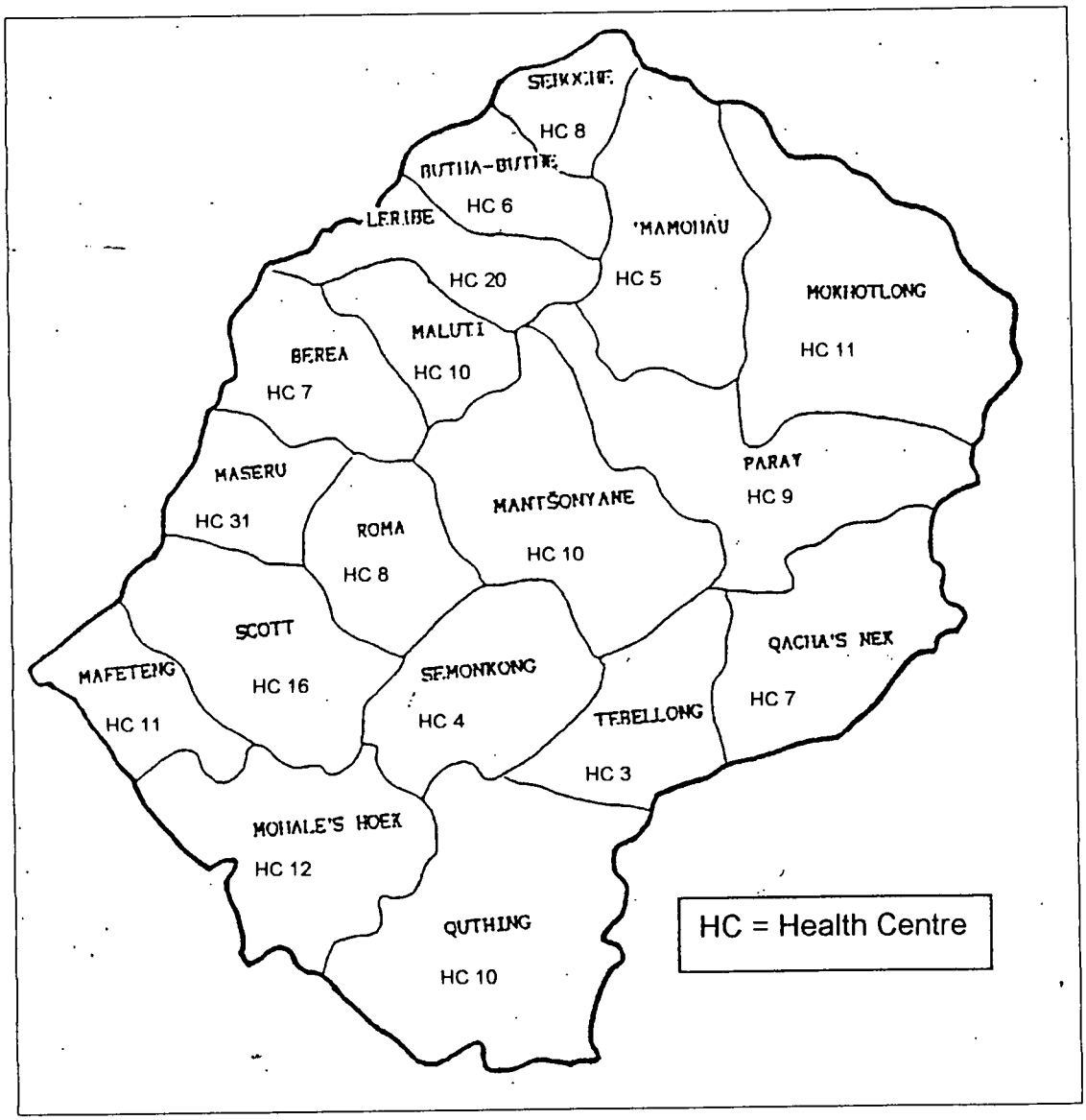

FIGURE 1.1: **Lesotho health service areas** (Source: MOHSW, 2001:1)

1.4 INTRODUCTION TO THE PROBLEM

The health of the adolescent population in developing countries has been largely ignored, since the focus has been mainly on the health of children under five years of age and that of adults. This is because traditionally young people have been seen as a healthy age group, since they have had a relatively low mortality rate compared to both older and younger age groups (World Health Organization [WHO], 1995, cited in Motlomelo & Sebatane, 1999:2). Lesotho is a member of the WHO and one of the developing countries, therefore the researcher believes that it is certainly no exception to this fact. The Minister of Health and Social Welfare concurs that insufficient attention has been given to the young people of Lesotho (MOHSW, 1994:i).

According to the UNFPA (1997) and Richter (2000:76), the world is now concerned about the health and education of adolescents because they face more serious health problems as they mature and become sexually active. Female adolescents face greater health risks because of factors related to reproduction. Such problems, among others, include unwanted pregnancies, maternal morbidity and mortality, Human Immunodeficiency Virus/Aquired Immunodeficiency Syndrome (HIV/AIDS) and sexually transmitted infections (STI's).

The Lesotho government has adopted the practice of family planning and the MOHSW is committed to the attainment of health for all, especially the younger population (Seipobi, 1991:144; MOHSW, 1994:i). Since the focus on adolescents is new, it is crucial to determine adolescents' knowledge and attitudes towards contraceptive services.

1.5 PROBLEM STATEMENT

According to Sechaba Consultants (as cited in Motlomelo & Sebatane, 1999:21), a significant proportion of young people is sexually active. Some female adolescents experience sexual intercourse at the young age of 13 and 14 years. However, under-utilization of contraceptives and contraceptive services appears to be a problem among female adolescents in the Maseru HSA. Little is known about adolescents' knowledge and attitudes towards contraceptive services since there is limited research addressing this issue in Lesotho. According to Morojele (cited in MOHSW, 1997:1), the incidence of adolescent pregnancy is 52.1%. This could indicate that the services are not reaching the target population.

1.5.1 Effects of under-utilization of contraceptives and contraceptive services

Contraceptive non-use is regarded as a risk behaviour for sexually active female adolescents, because it exposes them to the risk of unwanted pregnancy which, in turn, may result in abortion. According to the Centre for Disease Control (CDC) (1999:47), access to abortion is widely restricted across Africa (except for South Africa as abortion is illegal in Lesotho), so an adolescent's decision to terminate a pregnancy does not only pose great health risks, but also entails engaging in a criminal act.

Unwanted pregnancy could harm the girl's future and destroy her employment opportunities, because pregnant adolescents are forced to leave school earlier and are less likely to further their education. They suffer devastating consequences because they face rejection by their friends, their peers are discouraged to associate with them; and they do not belong to a group of peers or of mothers. It is also common for young single Basotho

men to deny parentage when a sexual partner becomes pregnant (MOHSW, 1994:27). Lesser, Ander and Koniak-Griffin (as cited in Lehana, 2000:7) point out that this rejection puts the adolescents at risk of developing adverse psychological and behavioural problems that could affect their lives, as well as the infants' health and development.

Traditionally a child born under the circumstance where the father denies parentage belongs to the parents of the girl. He/she is regarded as illegitimate and some of those children are discriminated against. The mother and the child grow up with a stigma (MOHSW, 1994:27; Maqutu, cited in Mturi, 2001:2).

According to the MOHSW (1994:28), another major consequence of early child-bearing is the heavy cost that the government must bear when young women drop out of school due to pregnancy. This confirms the need for the provision of information and services to the adolescents on family life education, including contraceptives to prevent unwanted pregnancies.

1.5.2 Measures ensuring accessibility of contraceptive services

The following efforts are made to ensure easy accessibility of contraceptive services:

- According to the existing policy of the MOHSW, family planning is to be provided as an integral part of all Mother and Child Health Services from the referral hospital Queen Elizabeth II to the lowest level clinics. No parental consent is required and Lesotho does not have a statute on contraception (MOHSW, 1994:18, 23).

- Government health facilities provide contraceptive services.

- Non-governmental organizations which are involved in health care also provide contraceptive services to compensate the effort of the MOHSW. Such organizations include the Lesotho Red Cross Society and the Lesotho Planned Parenthood Association, which offer contraceptive services at speciality clinics and outstations (Seipobi, 1991:146).

Despite all these efforts, the level of contraceptive usage remains low and the epidemiological profile of adolescents in Lesotho shows a high incidence of adolescent pregnancy at 52.1% (Morojele, cited in MOHSW, 1997:1). This leads to the following question: What are the knowlodge and attitudes of unmarried female adolescents in the Maseru HSA with respect to the use of contraceptives and contraceptive services?

It is against this background as outlined above that this research is proposed to determine unmarried female adolescents' knowledge and attitudes towards the use of contraceptives and contraceptive services.

1.6 PURPOSE OF THE STUDY

Based on the above-mentioned problems, the purpose of this study is:

- To explore and describe unmarried female adolescents' knowledge and attitudes towards contraceptives and contraceptive services and recommend strategies for implementation within the Maseru HSA that will promote utilization of such services.

1.6.1 Objectives

In accordance with the purpose of the study, the objectives are:

- To explore and describe adolescents' knowledge about contraceptives.
- To identify misconceptions regarding contraceptives.
- To explore and describe adolescents' attitudes towards the use of contraceptives.
- To assess adolescents' knowledge of contraceptive services in the Maseru HSA.
- To determine adolescents' attitudes towards contraceptive services.
- To make recommendations with a view to developing strategies for implementation to promote the utilization of contraceptives and contraceptive services.

1.7 CONCEPTUAL FRAMEWORK

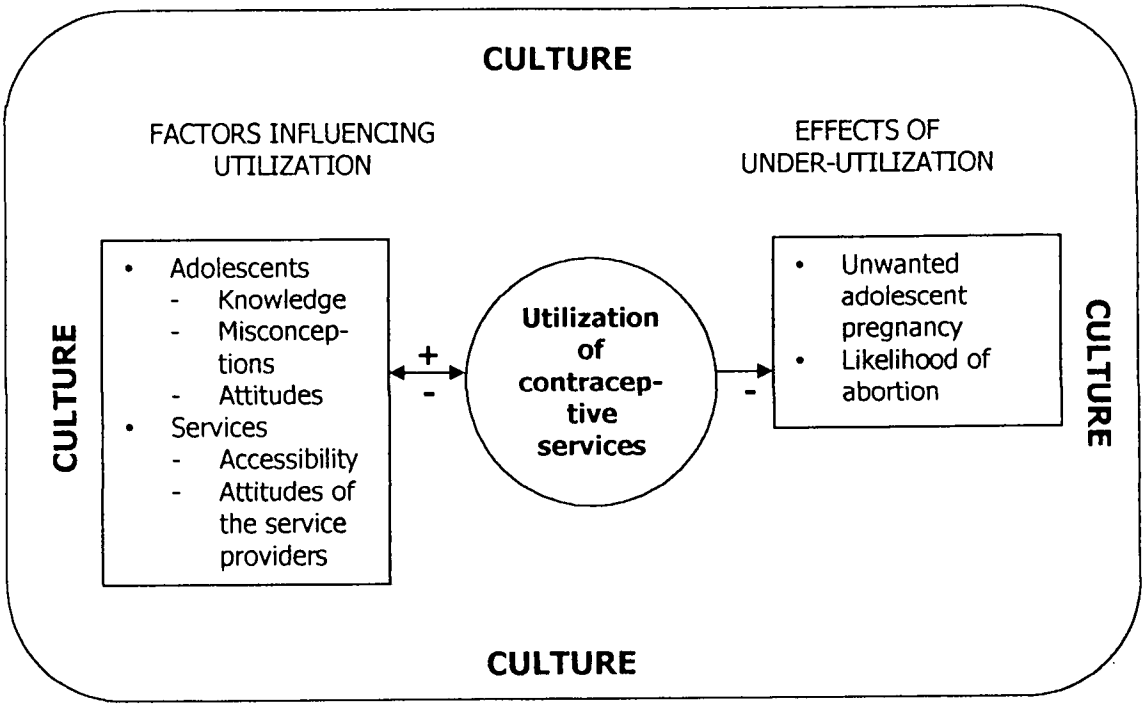

FIGURE 1.2: Conceptual framework

1.7.1 Relationship of concepts

There are possible factors that may influence the utilization of contraceptive services either negatively or positively. Some factors are related to the adolescents while others are service related and they also have a direct influence on one another.

Regarding adolescents, their knowledge and or misconceptions and attitudes will probably influence them to use or not to use contraceptive services.

Where the services are concerned, accessible services and good attitudes of the service providers will influence the adolescents to utilize the services. However an inaccessible service and negative attitudes of the service providers that do not comply with the principles of adolescent-friendly services, will lead to under-utilization of contraceptive services.

Under-utilization of contraceptive services may have a negative impact on the adolescent concerned. Unwanted adolescent pregnancy may occur, and there is also a likelihood of abortion.

It must be remembered that the behaviour of the adolescents and the service providers is influenced by their culture. They share and belong to the same culture of Basotho. The shared products of culture include values, definitions of right and wrong and ways of living (Popenoe, Cunningham & Boult, 1998:24). Basoitho culture disapproves premarital sex and use of contraceptives (Mturi, 2001:2).

1.8 DEFINITIONS

Adolescent

The WHO (1999:2) defines the 10 to 19 year old age group as adolescents.

According to Louw, Van Ede and Louw (1998:384) the age at which the adolescent stage begins varies from 11 to 13 years and ends between 17 and 21 years.

For the purpose of this study, *"adolescent"* refers to a girl between 13 and 21 years of age

Knowledge

These are facts, information, understanding and skills that a person has acquired through experience or education (*Oxford Advanced Learners Dictionary*, 2000:656).

Attitude

Is a mental state of readiness, learned and organized through experience, exerting a specific influence on a person's response to people, objects and situations with which it is related (Ivancevich & Matteson, 1996:126).

Family planning/contraception

Family planning is the use of recommended available contraceptive methods by sexually active women (Seipobi, 1991:144).

"Contraception" is the intentional prevention of pregnancy or conception (*Word Power Dictionary*, 1996:217).

For the purpose of this study the terms are used interchangeably and refer to a way of fertility control, using modern contraceptives to ensure that a woman can have a baby only when she is ready to have one.

Service

Organized system of labour, equipment etc. to provide public needs (*Word Power Dictionary*, 1996:1006).

Misconceptions

"Misconception" is defined as a mistaken belief (*Word Power Dictionary*, 1996:674).

Under-utilization

"Utilize"– use (*The Little Oxford Dictionary*, 1994:731).

"Underuse"– not use to capacity (*The Little Oxford Dictionary*, 1994:723).

For the purpose of this study, under-utilization means that contraceptives and contraceptive services are not used to their full capacity.

Accessibility

The accessiblity of health services refers to the extent to which community health nursing services reach people who need them the most (Stanhope & Lancaster, 1996:238).

"Accessibility" can be broken down into the following components:

- *"Geographical accessibility"* means that health services should be within a reasonable distance (the WHO suggests five to 10 km).

- *"Financial accessibility"* means that the levels of health care should be aligned to what the community and the country can afford.

- *"Functional accessibility"* means that the appropriate type of care should be available to meet the needs of the specific community.

- *"Cultural accessibility"* means that the health services should be rendered according to the cultural norms of the consumer (Dennill, King & Swanepoel, 1999:6; Dreyer, Hattingh & Lock, 2000:156).

For the purpose of this study, *"functional accessibility"* includes rendering the services in a manner that ensures emotional comfort of the client.

Abortion

Abortion – Unlawfully and intentionally killing and causing expulsion from the uterus of a humabn foetus (Hunt, 1970:308).

Therapeutic abortion – This is an abortion in which the uterus is evacuated by a qualified medical doctor for a valid medical reason in the interest of the mother's life (Sellers, 1993:1008).

Criminal abortion – This is an intentional termination of pregnancy under any condition prohibited by law (*Mosby's Medical & Nursing Dictionary*, 1986:301).

For the purpose of this study, *"abortion"* refers to the illegal termination of pregnancy by skilled or unskilled people to get rid of the unwanted pregnancy.

Adolescent pregnancy

Pregnancy is a period between conception through complete delivery of the products of conception (Jensen & Bobak, 1985:1411).

For the purpose of this study, *"adolescent pregnancy"* refers to pregnancy occurring between 13 and 21 years of age.

Culture

This means a way of life of the members of the society, the collection of ideas and habits which they learn, share and transmit from generation to generation (Haralambos & Holborn, 1991:3).

1.9 RESEARCH DESIGN AND METHODOLOGY

A non-experimental descriptive and exploratory design will be used because there is limited research on unmarried adolescents' knowledge and attitude towards the use of contraceptives and contraceptive services in Lesotho and adolescent reproductive health is a relatively new subject. According to Burns and Grove (1997:30), descriptive studies are usually conducted when little is known about a phenomenon. On the other hand, exploratory study is used to explore a topic when the subject of study is relatively new (Babbie & Mouton, 2001:80).

1.9.1 Research techniques

To assess knowledge and attitudes regarding the use of contraceptive services, a questionnaire will be used.

To design the questionnaire, available literature and focus groups will be used.

➲ *Literature review*

Review of relevant literature will be done to find the existing information on adolescents' knowledge and attitudes towards the use of contraceptives and contraceptive services. However, there is limited literature available since limited research has been done specifically to address this topic in Lesotho. Only tentative questions will be formulated. Therefore, to increase the validity of the questionnaire, focus group interviews will be conducted.

➲ *Focus groups*

Focus groups are group discussions exploring a specific set of issues. The group is *"focused"* in that it involves some kind of collective activity such as viewing a video, examining a simple health promotion message or simply debating a set of questions (Kitzinger & Barbour, 1999:4). The objective of the focus group interviews is to build the knowledge base on which to compile the questionnaire.

For this study, two focus group interviews will be conducted with the age groups 13 and 16 years and 17 to 21 years. After the analysis of the focus group interviews, the domains and themes identified during the discussion will be incorporated in the questionnaire.

➲ *The questionnaire*

The information obtained from the literature and the focus group results will be used to formulate the questionnaire which will be used as the primary research technique. It will be available in English and in Sesotho.

1.9.2 Population and sample

The target population for this study is unmarried female adolescents between 13 and 21 years within the Maseru HSA.

The accessible population is female adolescents at high schools because it is difficult to contact them at the clinics, because they do not utilize the services.

The purposive sampling method will be used to select respondents for the focus group interviews and a simple random sampling technique will be used to select 1,000 respondents for the questionnaire, which will be based on a proportional representation of all the schools in the Maseru HSA.

1.9.3 Pilot study

A pilot study is a smaller version of a proposed study conducted to refine methodology. It is conducted to determine the feasibility of the study; to examine the validity and the reliability of the research instrument; or to identify any problem in the research process (Van Ort, 1981, cited in Burns & Grove, 1997:52). A pilot study will therefore be conducted on adolescents who meet the sampling criteria, but who will not be taking part in the main study. The results will be used to modify the questionnaire where necessary.

1.9.4 Data collection process

After obtaining permission from the relevant gatekeepers, data collection will start with focus group interviews, which will be facilitated by a trained psychiatric nurse, while the researcher will be present as an observer taking notes. The results of the interviews will be used to compile a questionnaire.

During the implementation of the questionnaire, the data will be collected by the researcher during school hours at the scheduled time. Self-administered questionnaires will be distributed to a group of students in the school hall or classroom, who will complete the questionnaire in the presence of the researcher. This procedure will be repeated in all the schools until the required sample size has been obtained.

1.9.5 Data analysis

Analysis of all data obtained will be done on the descriptive nominal level. Data obtained through focus group interviews will be analysed according to the appropriate qualitative analysis methods, using the steps described by Tesch (cited in Creswell, 1994:155) (see discussion in Chapter 3). Statistical analysis of data obtained through the questionnaires will be done by the Biostatistics Department at the University of the Freee State, using the SAS computer programme. Descriptive statistics, namely frequencies and percentages for categorical data and/or medians and percentages for continuous data, will be used to reduce, organize and to give meaning to the data.

1.10 VALIDITY AND RELIABILITY OF THE STUDY

Denzin (cited in Polit & Hungler, 1991:383) recommends triangulation as a strategy to ensure validity and reliability of the research project. Data triangulation and methodological triangulation will be used to increase validity and reliability of the study. A literature study and pilot study will be done to validate the questionnaire. The content validity of the questionnaire will be assessed by the expert and evaluation committees of the Faculty of Health Sciences at the University of the Free State. This will be further assessed by

the domain experts at the Ministry of Health. The simple random sampling with representativeness of the target population will increase validity and reliability of the study.

1.11 ETHICAL CONSIDERATIONS

Treece and Treece (1986:126) maintain that ethical dilemmas such as taking advantage of the respondents must be avoided. The following ethical consideration will be adhered to:

- The researcher will obtain approval from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State, the Ministry of Health and the Ministry of Education in Lesotho.
- Informed consent of the participants and the parents will be obtained.
- Confidentiality and anonymity of respondents will be ensured.
- Participation will be voluntary and the respondents will be given freedom to withdraw at any time they feel the need.

This will be discussed in detail on page 73.

1.12 VALUE OF THE STUDY

The Ministry of Health and Social Welfare in Lesotho is in the process of developing the reproductive health policy. The results of this study will provide base-line information necessary to formulate the policy guidelines in an effort to improve the reproductive health of the adolescent population, specifically in relation to the contraceptive services. As indicated in the

problem statement, the rate of adolescent pregnancy is increasing. To alleviate this problem, barriers to the use of contraceptives and contraceptive services should be identified and removed to improve utilization of contraceptive services and prevent unwanted pregnancies. Ideally every child should be planned for, wanted and cared for by responsible parents.

Adolescents represent a valuable social group and a large proportion of the population, so it is important to improve their health status because a healthy and generally well-educated youth leads to a society that is able to meet the future challenges in life, and has the capacity to prepare a better future for subsequent generations (Motlomelo & Sebatane, 1999:2; Richter, 2000:76). Therefore, this study is important to the adolescents, the Ministry of Health and the country at large, as well as Africa as a whole. This research has direct implications on nurses and nursing, because nurses are in the majority at the health facilities, so the findings will guide the provision of contraceptive services to the adolescents and they will also add to the existing body of knowledge of nursing.

1.13 STRUCTURE OF THE REPORT

The structure of the report is as follows:

- **Chapter 1:** Introduces the study and entails the background information about Lesotho; the introduction and the problem statement.

- **Chapter 2:** Reviews the existing literature on the knowledge and attitudes of unmarried adolescents towards the use of contraceptives and contraceptive services nationally and internationally.

- **Chapter 3:** Addresses the focus group interviews, giving the description, data collection process and the results.

- **Chapter 4:** Presents the research methodology used in the study.

- **Chapter 5:** Reports the analysis of the collected data.

- **Chapter 6:** Presents the discussion of the findings, the conclusions reached and the recommendations made.

1.14 SUMMARY

In this chapter the study was introduced and the reproductive health problems facing female adolescents in Lesotho were explained. The purpose and objectives of the study were formulated to guide the study. The review of the relevant literature will be presented in Chapter 2.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter focuses on a review of the relevant literature as background to the problems and forms part of the data triangulation. Multiple data sources addressing similar issues were used to obtain a wide range of the existing information about the adolescents' knowledge and attitudes towards contraceptives and contraceptive services.

2.2 ADOLESCENCE

It is a stage between childhood and adulthood and is a time of rapid and uneven development. During this stage physical and psychosocial changes occur which are taxing and utterly confusing at times. This is a period of living in *"no man's land"*, having left childhood yet remaining far from adulthood. It is a period of inquiry into *"Who am I?"* (Seltzer, 1989:17; Fisher, 1994:322; Encarta Encyclopedia, 2000:1 of 1; Abebe, 2001:98).

According to Erickson's psychosocial stages, it is a state of **identity versus role confusion**. Adolescents start to regard themselves as unique persons with their own identity value system. If this development fails to take place, confusion and insecurity develop (Louw, Edwards, Foster *et al.*, 1998:501; Louw, Van Ede & Louw, 1998:426). Abebe (2001:98) maintains that a considerable proportion of adolescents fail to adjust to the various demands

of life and reveal their frustrations through conflicts with families, involvement in crime, suicide attempts and dropping out of school.

2.2.1 Characteristics of adolescence

This stage is characterised by trial and error/natural experimentation. Adolescents develop the urge to become self-dependent and child-parent conflicts increase due to the generation gap. They have flourishing sexual feelings and impulses combined with the beginning of the capacity to reproduce. They start developing social relationships outside the home. Adolescence is a time of opportunity and risk; what they do at this time will affect them throughout their lives and will have impact on their children (Louw, Van Ede & Louw, 1998:384; WHO, 1999:20; Sexually Transmitted Diseases [STD] Services, 2000:2 of 4).

In the light of these characteristics, it is obvious that adolescence is a stage of great vulnerability. Mistakes made during this period especially regarding reproductive issues can have far-reaching negative implications on the adolescent, e.g. contracting HIV and unwanted pregnancy. Therefore they need to be encouraged to use their energy and creativity towards positive health choices. According to the WHO (1998:6) the slogan of the WHO day in 1998 was *"Pregnancy is special – let's make it safe"*. This is ensured when pregnancy is planned and wanted, so adolescents need access to and information about reproductive health and family planning.

2.3 ADOLESCENT HEALTH

Adolescent health did not receive sufficient attention until recently; hence there is little information available to guide planners, decision-makers and service providers to organize and/or provide appropriate adolescent health services. *"Healthy young people equals a brighter tomorrow"* was the theme of the International Nurses Day in 1997, therefore it is important to ensure that adolescents are generally healthy and well educated so that they can be able to make valuable contributions to the economy of the country (International Council of Nurses (ICN), 1997:73). The WHO (1999:151) confirms that neglect of the adolescent population has major implications for the future, since sexual and reproductive behaviours during adolescence have far reaching consequences for people's lives as they develop into adulthood.

Promoting adolescent sexual and reproductive health – in particular that of girls in the developing world has become a major issue on the international agenda. With the Cairo Program of Action at the International Conference on Population and Development in 1994 and again with the Beijing Platform at the Fourth International Conference on Women in 1995, the global community resolved to protect and promote the rights of adolescents regarding sexual and reproductive health information and services. Family planning and pregnancy and the prevention of STI's were seen as central but insufficient components of a more encompassing approach to reproductive health (UN cited in Birtthistle & Whitman, 1997:1; Center for Reproductive Rights, 2003:1 of 1).

Lesotho is a signatory to the agreements reached at these conferences and countries are faced with the actual implementation of the reproductive health services. This political commitment resulted in the establishment of a National Adolescent Health Promotion and Development Programme for Lesotho.

Health promotion and protection for the youth have now been recognized as one of the most important health determinants of present and future generations (MOHSW, 1997:1; Vernon & Foreit, 1999:200).

2.4 ADOLESCENT SEXUALITY

Sexuality is a fundamental aspect of human life and a phenomenon that spans the entire life cycle. Because of the extensive physical development during puberty, adolescents become increasingly aware of their sexuality. They develop sexual attraction towards members of the opposite sex; they also develop a need for sexual exploration and an expression of sexual feelings. According to the studies, misinformation and lack of information about sexuality simply increase sexual confusion and vulnerability (AL-Ginedy, El-Sayed & Darwish, 1998:76; Louw, Edwards, Foster *et al.,* 1998:400).

A study has been conducted on adolescents' health problems in the three districts of Lesotho, namely Maseru, Leribe and Mafeteng. It revealed that 32% of the unmarried female adolescents were sexually active. Some female adolescents experience sexual intercourse at the young age of 13 and 14 years (Motlomelo & Sebatane, 1999:21). According to Summerton (2001:110), sex is a norm among young people; it is believed that it is a manifestation and an expression of love. Some young girls engage in sexual intercourse at an early age for material gain or favours from their sexual partners. Other reasons for early sexual intercourse include coercion and violence, while some young girls are the victims of older men's choices – the *"sugar daddy"* phenomenon which is particularly widespread in African cities (Silberschmidt & Rash, 2001:1816).

2.5 CONTRACEPTIVE SERVICES

Family planning is now seen as a human right basic to human dignity. Adolescents are therefore entitled to use contraceptive services (Hatcher, Rinehart, Blackburn & Geller, 1997:iii). It is crucial to provide counselling for family planning to the adolescents, because it is helpful in personalizing information to ensure relevance to the adolescents' special needs. It helps them to make informed decisions about reproductive health and family planning (Hatcher *et al.*, 1997:3-1; WHO, 1999:83).

2.5.1 Benefits of contraceptive services

A person can benefit from family planning in many ways: many lives are saved from high-risk pregnancies and unsafe abortions. Oral combined contraceptives help reduce menstrual cramps and pains; they stop anaemia; and prevent several types of cancer. Condoms help prevent STI's including HIV/AIDS. Family planning also provides a better life for the user and improves family well-being (Hatcher *et al.,*1997:2-1)4. An adolescent girl for example can be able to complete her studies without interruptions, thus paving the way for better employment opportunities.

2.5.2 Contraceptive services in Lesotho

According to the existing policy of the MOHSW, family planning is to be provided as an integral part of all mother and child health services. No parental consent is required (MOHSW, 1994:23). Therefore family planning services are provided at government health facilities, Lesotho Planned Parenthood Association clinics and other Christian Health Association of Lesotho institutions. A supermarket approach has been adopted in some of these health facilities, while other service areas have special family planning

days during which the service is provided (Seipobi, 1991:145). Seipobi (1991:147) further states that nurses are in the forefront of family planning services. This is attributed to the fact that they are closest to the individuals and community members.

A variety of modern methods of contraception are available at the health facilities in Lesotho. These include oral contraceptives, intrauterine contraceptive device, injectables, condoms, foams and jellies (Seipobi, 1991:145).

However, health centres run by the Roman Catholic Church (RCC) do not offer modern contraceptives. The RCC has the second largest number of health centres with the government owning the largest number (Lesotho Government, cited in Makatjane, 1997:13). Based on this situation, it is possible that adolescents living next to the Catholic clinics will not be able to obtain contraceptives even if they want to, or else they will have to walk long distances to other clinics, making the service geographically inaccessible.

2.5.3 Adolescents' knowledge and utilization of contraceptives and contraceptive services

Despite the benefits of contraceptive services and the efforts of the Ministry of Health stated in the previous paragraphs, the use of contraceptives is relatively low among the sexually active adolescents. According to Motlomelo & Sebatane (1999:53), only 29% of the adolescents in three districts of Lesotho indicated that they were using contraceptives. Olowu (1998:49) states that a baseline survey of family planning clients in Nigeria revealed that only 2% of adolescents were utilizing the services.

Although it is assumed that knowledge will always affect behaviour, it is not the case with contraceptives. According to the findings of the survey conducted in 20 African countries, knowledge did not correspond with use, since most of the adolescents were knowledgeable about modern contraceptives, but usage was generally low (CDC, 1999:53). Mbizvo, Bonduelle, Chadzuka, Lindmark and Nystrom (1997:200) state that the 1994 demographic health survey in Zimbabwe reported a contraceptive use prevalence of 47% and knowledge on contraception of up to 99%. Probably knowledge about contraceptives is not always an indication of use.

However, contraceptive practice varies considerably by place of residence and level of education. Social conditions in the rural areas limit educational opportunities and encourage early marriage and childbearing. Therefore non-use and the incorrect use of contraceptives are common in poorly educated adolescents living in the rural areas. Social conditions in urban areas promote education and delayed marriage, so the use of contraceptives is high among educated adolescents living in the urban areas (CDC, 1999:47).

2.6 CONSEQUENCES OF UNDER-UTILIZATION OF CONTRACEPTIVES AND CONTRACEPTIVE SERVICES

2.6.1 Unwanted adolescent pregnancy

Adolescent pregnancies imply adverse health, social and economic implications for the mothers and their babies and also for their families, because they place a massive emotional strain on the individual and a drain on the household income (Korra & Haile, 1999:107).

Although adolescents are mature enough to get pregnant, their bodies are often not sufficiently developed to have a safe pregnancy and delivery. According to a survey conducted among adolescent mothers in the Republic of South Africa, those younger than 16 years reported complications with regard to pregnancy-induced hypertension, anaemia, premature labour and prolonged labour due to cephalo-pelvic disproportion (Ehlers, Maja, Sellers & Gololo, 2000:44; Foy & Dickson-Tetteh, 2001:113). This is an indication that they are more vulnerable to pregnancy-related complications than adult women.

On the other hand, to some adolescents pregnancy may not be entirely unwanted. A conception proves a woman's fertility and is sometimes seen as a bargaining tool/an instrument through which to obtain favours from the male partner, and possibly also to demonstrate the capability to have a child (Otoide, Oransaye & Okonofua, 2001[a]:80).

2.6.1.1 Abortion

Under-utilization of contraceptives coupled with high rates of unwanted pregnancies has led to reliance on abortion, which is considered a crime under the Common Law in Lesotho (Hunt, 1970:307). According to the CDC (1999:47), access to abortion is widely restricted across Africa, so an adolescent's decision to terminate a pregnancy poses great health risks as well as engaging in a criminal act. Records from hospitals in Lesotho show a high incidence of abortion among female adolescents. Although there are no statistics on illegally performed abortions, 54.6% of the gynaecological procedures performed on young people below 24 years of age at Queen Elizabeth II Hospital from January to September 1994 were incomplete abortions. However, in countries where abortion is illegal like in Lesotho, official figures may underestimate the magnitude of the problem since some

of them avoid going to the health facilities for help (MOHSW, 1994:25; Motlomelo & Sebatane, 1999:7).

Every year 20 million unsafe abortions take place world-wide, killing approximately 200 women a day. Women aged 15-19 years have at least five million abortions a year. Around 75% of unsafe abortions take place in developing countries. Apart from women who die, millions of them suffer long-term health problems, including chronic pelvic pain, tubal blockage and infertility (WHO, 1994:34; WHO, 1998:8). Many of these deaths could be avoided if adolescents had access to information and contraceptive services. Considering the broad-based population pyramid in Lesotho with females in the majority, unwanted pregnancies and abortions should be prevented through utilization of contraceptive services to ensure a healthy nation.

Morojele (cited in Motlomelo & Sebatane, 1999:22) reviewed court cases of abortion in Lesotho and found many reasons why women resorted to unsafe abortions. The most common was fear of being expelled from school, which has serious implications for the future of the adolescent concerned. According to Silberschmidt and Rash (2001:1818; 1821), in a study conducted in Dar es Salaam some adolescent girls decided on an abortion when their sexual partners denied paternity, while others used abortion as a contraceptive method because cultural and practical barriers including access to contraceptives present greater obstacles (shame) than the risk of having an abortion.

A study conducted in Nigeria reported that adolescents seek abortion rather than contraception because of the perceived threat of sustained interference with fertility. This concern is in line with the fact that modern contraceptives are used continuously over a lengthy period of time, while abortion may be required only occasionally with short-lived effects and it poses no real or

immediate threat (Otoide *et al.*, 2001[a]: 80). However, abortion currently illegal in Nigeria (Otoide, Oransaye & Okonofua, 2001[b]:298).

2.6.1.2 Adolescent morbidity and mortality

In Lesotho, as in other countries morbidity and mortality have been observed, particularly adolescents illnesses related to sexual practices. Adolescents are mostly endangered by their own behaviour, for example multiple sexual partners and unsafe sexual practices, resulting in STI's, including HIV/AIDS. Contraceptive non-use can be regarded as a risk behaviour in that it exposes one to the risk of unwanted pregnancy (Flisher, 1992:19; MOHSW, 1997:1; Flisher & Chalton, 2001:235).

The epidemiological profile of adolescents in Lesotho shows a high incidence of STI's at 37% and teenage pregnancy at 52.1% (MOHSW, 1997:1). According to Maw and Letsie's (1999:14) report, an analysis of STI's reveals that the Maseru HSA is the second highest in STI's in the age group 15 to 19 years. Of those with STI's 11.2% were found to be HIV positive, while 6% had developed full blown AIDS. The MOHSW (1997:1) states that deaths resulting from pregnancy-related complications have also been reported in Lesotho, but there is no data available on adolescent mortality due to the lack of an effective and vital registration system.

2.6.1.3 Poverty

Adolescent pregnancy is thought to cause poverty because it causes a drain on the household income, and adolescent fathers are not usually prepared to contribute financially to the well-being of their children. Families headed by teen mothers are seven times more likely to live below the poverty line than other families. It is estimated that half the population of Lesotho live below

the poverty line. Daughters of adolescent mothers are 83% more likely to become teen mothers themselves and their sons are 2.7 times more likely to land in prison than children of mothers who delayed childbearing, thus continuing the vicious cycle of poverty (Mbizvo *et al.,* 1997:200; Pierre & Cox, 1997:310; Robinson & Calder, 2000:14).

2.6.1.4 School drop-outs

There is evidence from the Ministry of Education in Lesotho (cited in Motlomelo & Sebatane, 1999:25; 31) that there is a high rate of school drop-outs both in primary and high schools. The reasons for dropping out of school include pregnancy and marriage. Once these adolescents are forced to leave school, their employment opportunities are reduced because they lack the necessary skills to enter the labour market. Their potential economic and non-economic contributions will be limited, as these young mothers will be forced to devote themselves to child care and rearing (Seboni, 1997:111; US Bureau of the Census, 1996:1). A study conducted in Brazil, reported that 25% of females had discontinued schooling due to marriage and parenthood (Behague, s.a.). Adolescent fertility worldwide continues to be a roadblock to girls' educational achievement, their status, and their full participation in society.

2.6.1.5 Social outcast

Premarital sex and childbearing are regarded as culturally and religiously immoral in Lesotho, so a pregnant adolescent and/or adolescent mother is treated as a social outcast. She is expelled from school, her peers are discouraged to associate with her and she does not belong to a group of peers or of mothers (MOHSW, 1994:27). This rejection puts the adolescents at risk of developing adverse psychological and behavioural problems which

may result in suicidal behaviours. The rate of suicidal behaviour has greatly increased and the largest increase is in the age group 15 to 24 years. Adolescent pregnancy was found to be one of the contributing factors to parasuicide and suicide (Mhlongo & Peltzer, 1999:72; 75). The stigma attached to premarital childbearing makes it difficult for the pregnant adolescent and/or adolescent mother to function normally as a part of society.

2.6.1.6 Effects on the children

According to Mbizvo *et al.* (1997:200), children born from unwanted pregnancies have been shown to suffer from malnutrition, abuse and neglect. They have impaired psychological and academic development. Other consequences include baby dumping and undesirable living conditions. In Lesotho these children are regarded as illegitimate; they do not know their position in the family as this is determined by marriage (Makatjane, 1997:2). These children probably grow up with a stigma attached to them.

2.7 BARRIERS THAT INHIBIT CONTRACEPTIVE USE

There are a number of barriers that prevent the utilization of contraceptives and contraceptive services by the adolescents:

2.7.1 Misconceptions

Misconceptions contribute to the cultural, behavioural and information barriers that prohibit users from seeking care when it is most needed (WHO, 1998/1999:44). According to Khokho (1997:4) and Foy and Dickson-Tetteh (2001:51), some misconceptions identified include the following: use of contraceptives is a sign of promiscuity; contraceptives could harm the woman or her partner; use of condoms may expose male partners to being

bewitched, as their semen is being collected in a tube; and that contraceptives cause deformities in babies as well as sterility in the female adolescents. It is clear that adolescents may feel uncomfortable and unsafe to use contraceptives because of these misconceptions.

2.7.2 Socio-cultural status of adolescents

Traditionally, the Basotho are not allowed to initiate sexual activities before marriage. Indulging in sex or talking about it is a taboo. Parents do not discuss sexuality with their adolescent children. Premarital childbearing is even more unacceptable and children who are born to unmarried women are regarded as illegitimate. There is social disapproval regarding the use of contraceptives which inhibits the adolescents from seeking family planning services freely because they are afraid of being seen at family planning clinics (MOHSW, 1994:24; Mturi, 2001:2). This is in keeping with Pick's findings (s.a.) which suggest that fear and shame were the commonly perceived emotions described by adolescents in Mexico, and that they prefer to obtain information on sexual issues, as well as procure condoms in anonymous ways.

The same sentiments are expressed by American and British professionals. They feel that a clinic offering contraceptive services should be labelled a general clinic so that *"nobody knows specifically what the adolescents are going for"* (Cromer & McCarthy, 1999:292). The interviewees shared the perception that in America there is lack of focus on prevention, health care facilities and families postpone anything of a sexual nature until there is a problem. The same thing is happening in Lesotho because culturally talking about sex and sexuality is a taboo (Makatjane, 1997:3).

Owing to gender power imbalances in Lesotho, the perpetual legal and cultural minority status of women has restricted their decision-making power in areas concerning their health as well as in access to reproductive and productive resources (MOHSW, 2000:19). Fekadu (2001:114) states that traditional roles and the cultural status of women in Ethiopia imply a subordinate status in decision-making. Considering these girls' young age and their minority status, they are under the threat from male advances, which often take the form of abduction and rape.

2.7.3 Unfriendly health services

According to ICN (1997:73) and Cromer and McCarthy (1999:292) contraceptive services are not considered to be user-friendly by the adolescents. Hours of operation for the services are not convenient for the adolescents, because they are closed after school hours yet most of the adolescents spend their time at school during the day. Some of the service providers judge the adolescents and they demean them about their life style. There is no privacy at the clinics, adolescents and adults all queue at the same place for service. There is little or no counselling provided to the adolescents during their visits to the clinics. Adolescents are also of the opinion that health workers cannot maintain confidentiality. Adolescents are not given sufficient information and education about contraceptive services.

2.7.4 Adolescents' risk-taking behaviour

Many adults have difficulty understanding why young people would jeopardize their career and personal potential by becoming pregnant during their adolescent years. Adolescents, however, view the world differently; they are risk-takers, because they are at the stage of natural experimentation. They engage in risky forms of behaviour like gambling, stealing, substance abuse

and casual sex, including paid sex (Moeliono, s.a.; WHO, 1999:20). It is possible that adolescents can have sex and not use contraceptives to see what will happen or they may not acknowledge that adverse consequences will happen to them. According to Stanhope and Lancaster (1996:669), adolescents often feel invincible and therefore do not anticipate any risk for the consequences related to their behaviour.

2.8 STRATEGIES TO IMPROVE UTILIZATION OF CONTRACEPTIVE SERVICES

2.8.1 Correcting misconceptions

Information, education and communication should be provided to the adolescents to help them make informed choices about their reproductive health. Hatcher *et al.* (1997:ix) recommend that this can be done in face-to-face discussions and counselling, through the mass media, and in community events. This will help them to remove their fears and allay their anxieties about the use of contraceptives.

According to the WHO (1999:56), basic information is a foundation upon which young people build knowledge and skills to cope with the world around them. Therefore, if there are no reliable sources of information, adolescents usually discuss their problems with their peers and they accept everything – right or wrong. The misinformation confuses them and affects their behaviour and decisions about the utilization of contraceptive services.

2.8.2 Providing reproductive health education through schools

Reproductive health education, including family planning, should be addressed through schools because they seem to play a major role in informing adolescents about pregnancy, marriage and other health issues (Motlomelo & Sebatane, 1999:55). Schools are a central part of communities, as they provide access to a large proportion of children in an organized way. They have the power and potential to reach adolescents because they have a professional workforce of teachers who are educating children at the critical developmental stage. Furthermore children can disseminate information and attitudes back to their families, communities and others (National Health Strategy, O'Byrne & Moleketi, cited in Williams & Reddy, 1998:33).

In Lesotho like in other countries, more children are now attending school. According to BOS/UNFPA (1996:39), 97.1% of the schoolgoing population aged five to 24 years are at school. The government of Lesotho is planning to introduce family life education in high schools, while the RCC which owns more than a third of the high schools is generally against the use of modern contraceptives. So the introduction of family life education might have problems being accepted in Catholic schools (Lesotho Government, cited in Makatjane, 1997:12).

An issue confronted worldwide is whether it is appropriate to address reproductive health in schools. One major concern frequently voiced by parents, teachers and schools officials is that sex education and the availability of contraceptive services will increase adolescents' interest and involvement in sexual behaviour. However, reports on reproductive health programmes in developed countries found that sex and HIV/AIDS education delayed sexual intercourse; decreased sexual activity; and increased adoption

of safer sexual practices among sexually active young people. The majority of reproductive health programmes in developing countries have not been evaluated (Birtthistle & Whitman, 1997:11; Soul City, 2000:25).

2.8.3 Creating adolescent-friendly health services

An adolescent-friendly health service should offer comprehensive health service encompassing illness prevention, health promotion, curative services, advocacy and counselling tailored to their needs, concerns and expectations, but also appropriate to the cultural setting. Health care providers must remember to be good listeners, to take a positive approach, and view adolescents as responsible individuals. They must also create a supportive environment that will enable the adolescents to make healthy choices (ICN, 1997:73). An adolescent-friendly service from the adolescents' perspectives is the one in which accessible, comprehensive and multidisciplinary care is provided in confidence by non-judgemental staff with good counselling and communication skills. It should be open after school hours and have a 24-hour help-line. Family planning providers in developed countries think that procedures for contraceptive provision should not require a pelvic examination and that privacy must be ensured (Cromer & McCarthy, 1999:287; Richter, 2000:80).

2.9 SUMMARY

The adolescent stage and its characteristics have been discussed to set the stage for a better understanding of the reproductive health problems facing the adolescents. Adolescent health is now gaining recognition and the views of the international world and the stance of the Lesotho Government regarding reproductive health issues have been discussed. Adolescent sexuality was also discussed. Contraceptive services, knowledge and

utilization were discussed, as well as the consequences of under-utilization of contraceptive services. Barriers to the utilization of contraceptive services were identified and elaborated upon. Lastly, strategies to improve the utilization of contraceptive services were discussed.

The information gathered from the literature study and the focus group results was used to compile a questionnaire. The focus group methodology and findings will be discussed in Chapter 3.

CHAPTER 3

The focus groups

3.1 INTRODUCTION

The purpose of the focus group interviews in this study was to enhance the content validity of the questionnaire, as there is limited literature available due to limited research addressing the unmarried female adolescents' knowledge and attitudes towards the use of contraceptives services in the Maseru HSA. In this chapter, a description of the focus groups, the data collection process and the results will be provided.

3.2 FOCUS GROUP INTERVIEWS

A focus group is an interview with a group of people who share a similar problem or who have experienced a similar life experience (Monette, Sullivan & Dejong, 1998:184; Yegidis & Weinbach, 2002:130). According to Polit and Hungler (1995:272), a group of usually five to 15 people is assembled for a group discussion under the guidance of a moderator. Survey researchers sometimes use focus groups as a tool for developing questionnaires as was the case in this study. They formed the basis for the formulation of the questionnaire.

Two focus group interviews were conducted for this study, as Babbie (1999:227) suggests that more than one focus group is convened in a given study, because a single group would be too atypical to offer generalizable insights. The groups were made up of adolescents of the following age

groups: 13 to 16 years and 17 to 21 years. The knowledge and attitudes towards the use of contraceptives were believed to be different in these groups due to their age differences and life experiences. The educational level was also expected to have an impact, since the 13 to 16 year olds were in the lower classes at school as compared to the 17 to 21 year olds.

The researcher opted for the focus group interviews for the following reasons:

- They encourage participants to express their opinions as representatives of the group rather than as individuals (Summerton, 2001:80). In this way fear of being intimidated by the facilitator or the researcher is eliminated.

- They may produce more elaborate information if group members' responses evoke conflicting beliefs and attitudes that require justification from each respondent (Madriz, 2000:836; Summerton, 2001:80).

- They encourage individuals to express beliefs, attitudes and knowledge that they regard as common among themselves (Burns & Grove, 2001:425).

- They are flexible. The facilitator can explore unanticipated issues as they arise (Burns & Grove, 2001:425).

- In focus group interviews, you *"get-10-for-the price-of-one",* which means they are less time-consuming since more than one individual is interviewed at the same time (Babbie, 1999:227).

- Focus groups are an excellent means of collecting information from adolescents (Babbie & Mouton, 2001:291).

3.2.1 Measures to enhance the trustworthiness of the focus group results

Trustworthiness was enhanced by using Guba's model as presented in Lincoln and Guba (cited in Krefting, 1991:214-222; Babbie & Mouton, 2001:276-278) and Creswell (cited in Leedy & Ormrod, 2001:106). The model identifies four criteria for assessing trustworthiness:

3.2.1.1 Credibility (truth value)

Credibility asks how confident the researcher is with the truth of the findings.

Credibility was enhanced by means of the following measures:

- First the researcher visited the selected schools before the interviews and introduced herself to the participants to build rapport. Contact was maintained by telephone and on the day of the interview the participants were transported to the clinic where the focus group interviews were conducted.

- The facilitator is a Mosotho, so is the researcher. Therefore the participants felt free to verbalize their views in their own language. Dashiff (2000:345) states that ethnic differences between researchers and adolescents can increase their self-consciousness or provoke defensive reactions that interfere with the quality of responses. In this case there were no ethnic differences and the quality of the responses was enhanced.

- Peer debriefing: The researcher exposed herself to a peer as a mechanism for guarding against bias and ensuring honesty. The peer takes a devil's advocate position. The researcher's colleague, who was also pursuing her master's degree in nursing, played the role of the debriefer.

- The question for the focus group was piloted to test whether it would generate appropriate responses, and it was found that it was able to generate the required information. This was done at a school which was not taking part in the study because it was not yet registered with the Ministry of Education. The discussions were not recorded.

- Member checking: The researcher solicited feedback from the participants by playing back the tape after the interviews. The aim was to correct errors or give additional volunteer information, but there were no additions made to the tape after the playback.

- Referential adequacy: The researcher had materials to document her findings. The interviews were recorded on audiotape, while the observations and notes were written in the notebook by the researcher during the focus group interviews.

3.2.1.2 Transferability (applicability)

This refers to the ability to generalize from the findings to the larger population (Babbie & Mouton, 2001:277).

The simple random sampling was used to select the schools where the respondents were obtained and purposive sampling was used to select vocal participants to share their views. The range of information obtained was maximised through the use of respondents with differences in age, educational level, religion and place of residence (rural and urban).

3.2.1.3 Dependability (consistency)

This refers to whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) respondents in the same (or similar) context (Babbie & Mouton, 2001:278).

Dependability is, however, not possible in focus group interviews because the knowledge and attitudes differ. This was persued by detailed data, which were collected and reported with sufficient detail. This description provides information as to how repeatable the study might be.

3.2.1.4 Confirmability (neutrality)

This is the degree to which the findings are the product of the focus of the inquiry and not the biases of the researcher (Krefting, 1991:216; Babbie & Mouton, 2001:278).

To ensure confirmability, the discussions were facilitated by a trained psychiatric nurse who had been selected from the psychiatric clinic at Queen Elizabeth II Hospital. She was selected for her skills and experience in group interviews. She was also involved in adolescent activities concerning mental health issues.

The roles of the researcher and the facilitator were clearly defined, because the facilitator facilitated the discussion while the researcher was an observer taking notes.

The interviews were recorded on audiotape and transcribed to avoid lost data. Transcriptions and the researcher's notes were used as the data set for analysis.

An annexure of the transcriptions and the researcher's notes are attached to the report (see Addendum J).

3.3 POPULATION AND SAMPLING

3.3.1 Population

The target population for the focus groups was the same as the population of the main study. It consisted of all unmarried female adolescents between 13 and 21 years in the Maseru HSA. The accessible population was adolescents at high schools.

3.3.2 Sampling

Two sampling methods were used:

- Simple random sampling was used to select four schools from which the respondents for the focus groups were drawn. Two schools were in the urban area and the other two in the rural area. The combination of rural and urban areas was intended to facilitate understanding of the phenomenon under study using people from different geographical locations.

➢ Purposive sampling was used to select participants who could verbalize their views freely from the four selected schools.

3.3.2.1 Sample inclusion criteria

The sample inclusion criteria included:

- All unmarried female adolescents between 13 and 21 years;
- who were attending high schools in the urban and rural areas of the Maseru HAS;
- who expressed willingness to participate; and
- who could verbalize their views freely.

3.3.2.2 Selection of schools

The names of the schools in the rural area were written on slips of paper and placed in one container. The slips were mixed well and two of them were drawn out one at a time.

The same procedure as described above was repeated to draw the names of two urban schools. This brought the total number of selected schools to four.

3.3.2.3 Selection of the respondents

After the random selection of schools, purposive sampling was then used to select typical participants for the focus groups who were willing to share their views freely. According to Burns and Grove (997:306), purposive sampling involves conscious selection by the researcher of certain subjects to include in the study.

The researcher did not have any prior knowledge of the students and it would not be possible to use her judgement to select the respondents, therefore the selection was done by the teachers. The researcher requested the teachers to select students for the research purposes only, that is those who could verbalize their views and were willing to participate in research.

The first group was that between 13 and 16 years old. Ten members were recruited for this group, but only eight were available on the day of the interview. Four of them were from the schools in the rural area and the other four from those in the urban area. The second group was that of the 17 to 21 years. Ten members were also recruited for this group and all of them managed to attend the interview. These 10 members were equally divided; five from the schools in the urban area and the other five from the schools in the rural area.

3.4 THE PROCESS OF FOCUS GROUP INTERVIEWS

After permission had been granted by the relevant authorities (see Addenda B, D and I), the researcher carefully planned the interviews. The respondents were contacted in advance, while contact was maintained with the relevant schools by telephone. The date and time of the interviews were arranged jointly by the researcher and representatives of the selected schools.

On the day of the interview, namely 7 August 2002, the participants were transported to Thamae clinic where the interviews were held. The first group was assembled in the clinic hall specifically prepared for the interview. Privacy was ensured. Permission was sought by the researcher to record the interview on audiotape, which was granted. The purpose of the study was

explained and before the discussion commenced, the following points were made clear:

- The interview would last for approximately one hour.
- They had a right to withdraw from the study at any time without penalty.
- Confidentiality of collected data was assured.
- The importance of everyone's point of view was stressed.
- There were no right or wrong answers to the questions asked during the discussion.
- They were reassured that repetition of responses was acceptable

The interview then commenced and the following open-ended question was asked:

"Why do you think female adolescents do not use contraceptives?"

The interview was recorded on audiotape and the researcher was present as an observer taking notes.

At the end of the discussion the participants were thanked for their time and co-operation. They were provided with lunch as a token of appreciation and also because lunch had already passed at their respective schools. Then they were transported back to their schools.

About one and a half hour later the second group was assembled and the same protocol was repeated.

Certain problems were experienced during the focus group interviews. A list of the problems and the way in which each was managed by the facilitator, are depicted in Table 3.1

TABLE 3.1: Problems and solutions of the focus group interviews

PROBLEMS	SOLUTIONS
Domineering respondent	The facilitator encouraged turn talks and emphasized the importance of everyone's point of view.
Voice clarity	The respondents were continuously encouraged to speak aloud so that group members could hear and the tape could be audible.
Changing roles (participant asking the facilitator)	The facilitator requested other group members to respond to the question.
Passive participants	The facilitator encouraged them to participate in the discussion. For example, a statement like "You have been quiet for some time" was made.
The discussion losing focus	The facilitator redirected the discussion.

3.5 DATA ANALYSIS AND RESULTS OF FOCUS GROUP INTERVIEWS

3.5.1 Data analysis

The analysis of the transcriptions was conducted manually. Acknowledging the voluminous nature of the qualitative data obtained through the focus group interviews, the first step in the analysis was to reduce the data so that it could be presented in a logical and simple way. The appropriate qualitative analysis methods described by Tesch (cited in Creswell, 1994:155) were used to analyse unstructured data.

The researcher read through both transcripts to obtain a sense of the whole and thoughts were written in the margin. Similar topics were clustered together. Data were then read for the second time, comparing them to the list of topics identified and categories were formed. Topics that related to one another were grouped together and a preliminary analysis was performed. Comparisons were made between the results of both focus group discussions to identify significant similarities and differences. The data were then integrated and synthesized into meaningful information, which was used to compile a questionnaire.

3.5.2 Findings

The transcribed interviews were organized into 10 broad themes following the steps described in the previous paragraph. The findings will be discussed under these themes.

3.5.2.1 *Misconceptions regarding contraceptives*

The majority of the respondents had misconceptions about contraceptives. This is evident from responses such as:

- *"We are afraid to use contraceptives at our age, because they cause sterility."*
- *"Girls who use contraceptives are promiscuous."*

3.5.2.2 *Unfriendly health services*

Most of the respondents indicated that services at the clinics were not adolescent-friendly, as they are insulted and embarrassed by the nurses. The following excerpts give a clear picture of what the adolescents had to say:

- *"We feel embarrassed, because we are insulted by the nurses before they can serve us."*
- *"We don't go near the clinics, we are afraid of being scolded."*

3.5.2.3 *Knowledge of contraceptives and their availability at the clinics*

Most of the respondents knew more than one contraceptive method and a few knew condoms only. Some knew the available methods at the clinics, while most of them did not know them. Their responses were given in the following examples:

- *"Some adolescents are not aware of these things. No one is advising them on what to do and not to do."*

- *"Adolescents have no idea about contraceptives, where to find them and how to use them. They are just like me they know condoms only, there is nothing that I can use except a condom."*

3.5.2.4 Communication between parents and their adolescent daughters

The results revealed that there is a lack of communication between parents and their daughters about reproductive health, as this is considered a taboo subject. This is reflected in the following excerpts:

- *"Our parents are afraid to talk to us about sex and family planning, they shout at us even when we ask questions."*

- *"Sometimes girls do not tell their parents when they start menstruating, so the parents will not be able to advise them."*

3.5.2.5 Pressure from the boyfriends

Most of the respondents indicated that they were under a lot of pressure from their boyfriends who wanted to have sex with them, but disapproved of the use of contraceptives. The following are examples of what they said:

- *"We as the female adolescents are afraid of our boyfriends more than we can take care of our health. When my boyfriend wants to have sex with me, I'm afraid that he will leave me if I don't and I end up sleeping with him."*

- *"Your boyfriend will tell you, I don't eat a wrapped sweet* ***(ha ke je pompong e phuthetsoeng,*** **meaning I will not have sex wearing a condom**). *You will try to refuse no; jo; no; but because of love you will eventually sleep with him without protection."*

3.5.2.6 Benefits of family planning/contraceptive services

Respondents acknowledged the benefits of family planning such as preventing abortion, AIDS, reducing poverty and preventing population explosion. Their responses are indicated in the following examples:

- *"Yes, I really say that contraceptives should be used, because it looks like adolescents increase the population greatly and our country is very poor."*

- *"Contraceptives are very good in the issue of abortion, because now we make unplanned babies, you are afraid to tell your parents and you end up performing an abortion, you are not safe, you can also die."*

3.5.2.7 Effects of unwanted adolescent pregnancy

The respondents were well aware of the consequences. They include abortion, poverty and population explosion. Other consequences are school drop out and destroyed future. Their views are reflected in the following excerpts:

- *"And maybe in the family you are already needy, your parents are struggling to get you to school and if you bring extra burden by having a baby it becomes difficult."*

- *"Contraceptives should be used by adolescents, because they engage in sexual activity young as they are, they end up not finishing school because of pregnancy and their future is destroyed."*

3.5.2.8 Appropriate age to start using contraceptives

Some respondents suggested that nurses should consider the age when providing family planning services and provide contraceptives to adolescents who are 18 years and above. Respondents had mixed feelings about this issue. Their opinions are reflected in the following excerpts:

- *"Adolescents less than 18 years old should not be given contraceptives."*

- *"I beg to differ, premarital sex and pregnancy that are happening now happen to people of our age. If we are prevented from using contraceptives we will find ourselves in danger of having babies."*

3.5.2.9 Use of contraceptives to prevent pregnancy that may result from rape

There was a general consensus in both groups that contraceptives should be used to prevent pregnancy that may result from rape. The following are the examples of what they said about rape:

- *"Adolescent girls are sometimes raped, and if they are on contraceptives unwanted pregnancies can be prevented because even if you have a condom there is no time to negotiate."*

- *"The rate of rape is increasing, sometimes innocent girls are raped and have unplanned children. So contraceptives can prevent these pregnancies."*

3.5.2.10 Under-utilization of contraceptive services by sexually active adolescents

Some respondents stated that it was obvious that sexually active adolescents did not use contraceptive services. Their views are indicated in the following example:

- *"When you visit the clinic for your physical problems you find that pregnant adolescents of our age are there attending antenatal clinic."*

3.6 SUMMARY

The focus group interviews were conducted as the basis for the formulation of the questionnaire. The collected data were analysed according to the thematic analysis. The findings are presented with direct quotes from the transcriptions. The identified themes were incorporated in the questionnaire. The design of the questionnaire will be discussed in Chapter 4.

CHAPTER 4

The research methodology

4.1 INTRODUCTION

This study was designed to explore and describe the knowledge and attitudes of unmarried female adolescents with regard to the use of contraceptives and contraceptive services in the Maseru HSA. As stated in the problem statement in Chapter 1 of this report, the focus on adolescent health is new and very little is known about rendering appropriate adolescent health services. This chapter outlines the research methodology (design and method) used and the course of the research process followed. The validity and the reliability of the study, as well as the ethical issues taken into consideration will also be described. Lastly, the data analysis process will be discussed.

4.2 RESEARCH DESIGN

The research design is defined by Mouton (1996:107) as the blueprint of the research project that precedes the actual research process. Based on the purpose of the study and in order to achieve its objectives, a non-experimental exploratory and descriptive design was used. Mouton (1996:108) further states that the rationale for a research design is to plan and structure a research project in such a way that the eventual validity of the research findings is maximised through either minimising or, where possible, eliminating potential error.

The exploratory nature of this study is due to the relative newness of the phenomenon of adolescent health with specific focus on contraceptive services. It was decided that an exploratory design would be more appropriate and it was used to gain deeper insights into the problem, which is the under-utilization of contraceptives and contraceptive services. Polit and Hungler (1991:19) and Babbie (1999:72) confirm that exploratory studies are done for the purpose of satisfying the researcher's curiosity and desire for a richer understanding of the phenomenon.

The descriptive nature of this study is due to the limited research in Lesotho addressing this topic, so it was used to generate new knowledge. Burns and Grove (1997:30) state that descriptive studies are conducted when little is known about a phenomenon.

The study utilized both qualitative and quantitative techniques to obtain a better and more substantive picture of reality, thereby increasing the overall validity of the study. This is referred to as triangulation (Berg, 2001:4). According to Burns and Grove (1997:241), triangulation is the combined use of two or more theories, methods, data sources, investigators or analysis methods in the study of the same phenomenon.

The researcher used method and data triangulation. According to Creswell (1994:175), recent authors have suggested that methods can be used developmentally where the first method is used to inform the second method. In this research the focus group interviews which is a qualitative research strategy were conducted first, then the results were used to compile a questionnaire, which was used to collect data on a larger sample. Padgett (1998:128) refers to this sequencing as the qual -> quant mode.

4.3 THE RESEARCH METHOD

A survey method was used to obtain the necessary data. This method was used for the following reasons:

- Surveys can be used to describe the opinions, attitudes and behaviours, as they currently exist in the unmarried female adolescents.

- Surveys typically involve collecting data from large samples, therefore they are ideal for obtaining data representative of the populations too large to be dealt with by other methods (Monette *et al*, 1998:156).

- This data collection in turn enables the researcher to generalize the findings from the sample to the population (Monette *et al.*, 1998:156).

- According to Creswell (1994:119), information is collected over a period of time in surveys. Therefore in this study data were collected over a period of four weeks.

- The respondents were asked questions specifically focused on the phenomenon of interest and the information obtained could be used to formulate guidelines to provide appropriate adolescent health services.

4.4 POPULATION AND SAMPLING

The population is defined by Burns and Grove (1997:293) as the entire set of individuals who meet the sampling criteria, sometimes referred to as the target population. Sampling on the other hand, refers to the process of selecting a portion of the population to represent the entire population

(Anderson, 1989:2). A sample then consists of the number of elements of the population being studied (Uys & Basson, 1991:87).

4.4.1 Population

The target population for this study consisted of all the unmarried female adolescents between 13 and 21 years in the Maseru HSA.

It was stated previously that there is under-utilization of contraceptive services by the adolescents, therefore it would be difficult to get them at the clinics. Therefore, the accessible population for this study were the female adolescents at high schools due to a high concentration of adolescents at this level of education.

4.4.2 Sampling

The simple random sampling method, using proportional representation, was used to select 1,000 respondents from all 31 high schools in the Maseru HSA registered with the Ministry of Education.

Sample inclusion criteria were the following:

- All unmarried female adolescents between 13 and 21 years.
- Who were attending high schools in the rural and urban areas of the Maseru HSA.
- Ability to read and write Sesotho or English.
- Willingness to participate in the study.

Sampling was done by the Department of Biostatistics at the University of the Free State.

The researcher provided the Department of Biostatistics with a list of all high schools in the area. There are 31 in all; 21 of them are in the urban area, while 10 are in the rural area. The list was based on the Ministry of Education 2001 statistical returns.

The list enabled the biostatistician to calculate the sample size per school on a proportional representation basis. The biostatistician then provided the researcher with lists of random numbers per school, which were used to draw the sample from the population, using the schools registers.

This random selection method provided a true representation of the target population, because it gave all the female adolescents at high schools an equal chance of being selected for the study (Brink, 1999:134). The proportional representation also enhanced representativeness, because more respondents were obtained from schools with many children.

The list of schools indicating the total population and the calculated sample size is presented in Table 4.1.

TABLE 4.1: List of schools showing the population and sample

SCHOOL	Population (N)	Sample (n)
School 1	83	12
School 2	56	8
School 3	113	16
School 4	145	21
School 5	127	18
School 6	48	7
School 7	93	13
School 8	74	11
School 9	167	24
School 10	374	54
School 11	290	42
School 12	283	41
School 13	247	36
School 14	238	35
School 15	248	36
School 16	320	46
School 17	304	44
School 18	287	42
School 19	103	15
School 20	337	49
School 21	219	32
School 22	367	53
School 23	261	38
School 24	311	45
School 25	411	60
School 26	409	59
School 27	193	28
School 28	113	16
School 29	268	39
School 30	184	27
School 31	226	33
Total 31	**6,898**	**1,000**

4.5 REPRESENTATIVENESS

According to Yegidis and Weinbach (2002:181), *"representativeness"* refers to the degree to which a research sample is similar to the population from which it was drawn. Burns and Grove (1997:295) maintain that it is especially important that the sample be representative in relation to the variables being studied and to other factors that may influence the study variables.

There are 31 high schools in the Maseru HSA registered with the Ministry of Education. All of them participated in the study (except two where permission was not granted). Some schools are located in the rural area while others are in the urban area, therefore representativeness in terms of location was ensured. The ownership of schools was shared between the government and different churches and this enhanced representativeness in terms of ownership. The random sampling with a proportional representation used to select the sample ensured representativeness regarding age, religion and education level.

The results of the study could possibly be applicable beyond the study context, because the characteristics of the schools and the students are used in this study similar to that of other schools and students all over the country.

4.6 RESEARCH TECHNIQUE

Research techniques are described by Bailey (cited in Tlaba, 2000:28) as instruments that are used to obtain the necessary data. The different techniques can be used on their own or in combination with one another.

This study is exploratory and descriptive in nature, so the feasible research technique was a questionnaire.

Justification for selection of a questionnaire as the primary research technique:

- A questionnaire can be used to determine the beliefs, knowledge and attitudes of the subject (Burns & Grove, 1997:358). Therefore, it was found to be more appropriate to obtain data on adolescents' knowledge and attitudes towards contraceptives and contraceptive services.

- Due to the sensitivity of the topic, many adolescents may not feel free in a face-to-face interview, so a questionnaire offers anonymity, which allows potential embarrassing questions to be asked with a fair chance of getting a true reply (Clifford & Gough, 1990:81).

- Questionnaires can be distributed to groups of individuals who complete the questionnaires together at the same time and this maximizes the return rate (Polit & Hungler, 1995:289).

- Self-administered questionnaires are less time consuming.

- There is less opportunity for bias than in interviews.

4.7 THE QUESTIONNAIRE

4.7.1 Design of a questionnaire

After a thorough literature review and analysis of the focus group interviews, a questionnaire was designed using the themes identified in both techniques to validate the questionnaire.

4.7.1.1 *Literature review*

A thorough literature review of different sources (books, journal articles, master's dissertation and doctoral theses and the internet) was done to acquaint the researcher with the existing information on adolescents' knowledge and attitudes towards the use of contraceptives and contraceptive services, both nationally and internationally. However, there is limited literature available, since limited research has been done specifically to address this topic in Lesotho. Themes identified in the literature were used to formulate tentative questions for the questionnaire. The literature review is presented in Chapter 2 of this report.

4.7.1.2 *Focus group interviews*

Two focus group interviews were conducted to increase the content validity of the questionnaire. For the description of the focus groups, see Chapter 3 of this report.

A summary of themes identified in the literature and focus group interviews is presented in Table 4.2.

TABLE 4.2: Themes identified in the literature and focus group interviews

THEMES	Literature	Focus group interview
• Misconceptions regarding contraceptives	Yes	Yes
• Unfriendly contraceptive services	Yes	Yes
• Different levels of knowledge regarding contraceptives	Yes	Yes
• Lack of communication between parents and their female adolescents	Yes	Yes
• Adolescents under pressure from the boyfriends	Yes	Yes
• Benefits of family planning	Yes	Yes
• Consequences of unwanted adolescent pregnancy	Yes	Yes
• Appropriate age to start using contraceptives	No	Yes
• Use of contraceptives to prevent pregnancy that may result from rape	No	Yes
• Under-utilization of contraceptive services by sexually active adolescents	Yes	Yes

Most of the themes were identified both in the literature and focus group interviews. Only two out of nine themes were identified in the focus group discussion, but not in the literature. The purpose of the focus groups was to increase the content validity of the questionnaire, therefore all the themes identified in the focus group interviews were incorporated in the questionnaire, as well as those identified in the literature.

The use of contraceptives to prevent pregnancy that may result from rape was not the focus of the study, but it emerged during the discussion in both groups. Therefore, it was incorporated in the questionnaire. Burns and Grove (2001:426) state that it is important to attend to the amount of consensus and interest in the topics generated in the discussion.

4.7.2 Structure of the questionnaire

The questionnaire was constructed in English and translated into Sesotho. It was then back-translated to ensure that the questions still maintained their original meaning. The final questionnaire was written in both English and in Sesotho (see Addendum K). It consists of close-ended and open-ended questions.

Topics related to a specific topic were grouped together as follows:

- **Section A** - Demographic data: Questions 1 to 4
- **Section B** - Knowledge about contraceptives: Questions 5 to 11
- **Section C** - Knowledge and attitudes about contraceptive services: Questions 12 to 23
- **Section D** - Sexual behaviour and attitudes towards contraceptives: Questions 24 to 34

Questions on sexual behaviour appeared in the last section, as Burns and Grove (1997:360) state, that questions of a sensitive nature should appear last in the questionnaire.

4.7.3 Validity and reliability of the questionnaire

The validity of an instrument refers to the degree to which an instrument accurately measures what it is supposed to measure (Brink, 1999:16).

Reliability refers to the consistency of measure obtained (Melville & Goddard, 1996:37).

Validity and reliability were enhanced by the following measures:

- The final questionnaire was compiled by using information gathered from the relevant literature and the focus group results to satisfy content validity.

- The questionnaire was constructed in English and translated into Sesotho. It was then back-translated to ensure that the questions still maintained their original meaning.

- The final questionnaire was written in both Sesotho and in English so that the respondents could use the language that they felt comfortable with.

- It was evaluated by a panel of experts at the University of the Free State and domain experts at the MOHSW. As a result, corrections and additions were made.

- A pilot study was done on 10 adolescents who met the sample inclusion criteria, but who were not taking part in the main study. The aim was to check if the questions could be understood and to determine the time that could be allocated for completion of the questionnaire.

- The questionnaires were administered personally by the researcher to the different groups of participants and this was consistent in all the schools, which is important with regard to validity.

- The respondents completed the questionnaires in the presence of the researcher and questions which were not understood, were clarified.

- The total data collection process took four weeks. Schools which were in close proximity to one another were done on the same day. This addressed the issue of the possible contamination of future respondents.

4.8 PILOT STUDY

A pilot study was conducted on 10 adolescents who met the sample inclusion criteria, but who were not taking part in the main study. The aim was to check if the questions could be understood and to determine the time that could be allocated for the completion of the questionnaire. It was also done to determine if the content of the questionnaire was acceptable to the participants.

The time taken to complete the questionnaire varied between 20 and 40 minutes. After the analysis and discussion with the participants the necessary amendments were made, e.g. using familiar words such as a *"boyfriend"* instead of a *"sexual partner"* and a *"condom"* instead of a *"barrier"*. In an attempt to use simple language that could easily be understood by adolescents as they suggested, *"in town and outside town"* were used instead of *"rural and urban areas"*. *"Family and friends are important to the adolescents, therefore they were used instead of the society."* But the general content was found to be acceptable to the pilot study respondents.

After the pilot study, the main study commenced on 25 September 2002.

4.9 DATA COLLECTION PROTOCOL

The data were collected by the researcher during school hours.

The proposed data collection schedule was drawn up and sent to the schools in advance. It was attached to the request letters (see Addendum E). The schedule was negotiated with the schools. Three weeks from 25 September 2002 to 17 October 2002 were allocated for data collection, but four schools did not agree to the proposed dates and gave their own, which extended the period to four weeks.

On the scheduled date the researcher went to School 1 with a list of random numbers for that particular school. The researcher was provided with school registers, which were used to draw the numbers until the required sample size was obtained. Only one number was replaced with the next number on the register, because the owner was said to be absent. This replacement strategy was used in all the schools. When a sample had been drawn, the

students gathered in the school hall, which had been prepared for data collection.

Before the administration of the questionnaire, the purpose of the study was explained, as well as the ethical considerations to ensure informed consent. They then signed the consent forms, which were not stapled to the questionnaire, but kept separate for anonymity purposes.

The self-administered questionnaires were distributed by the researcher to the participants. They completed the questionnaires in the presence of the researcher to ensure that they did not discuss the answers and to clarify questions that were not understood. Twenty to 40 minutes was allocated for completion of the questionnaires, which were collected by the researcher after completion. The completed questionnaires were placed in an envelope and was sealed to ensure that no one gained access to the raw data. The respondents were then thanked for their participation. This data collection protocol was followed in all the participating schools.

There are 31 high schools in the Maseru HSA and 29 participated in the study. Two schools did not give the researcher permission to access their students and their decisions were honoured. These schools are indicated as *"school 3"* and *"school 19"* in Table 4.3. The number of respondents initially selected by the biostatician are 16 and 15 respectively making a total of 31. The final sample size was 969.

4.10 VALIDITY AND RELIABILITY OF THE STUDY AS A COHERENT WHOLE

Triangulation has been generating interest as the most important strategy that increases the overall validity of the studies (Burns & Grove, 1997:241). According to Polit and Hungler (1991:383), triangulation is used to sort out *"true"* information from *"error"* information. Therefore the validity and the reliability of the whole study was enhanced through different types of triangulation.

4.10.1 Data triangulation

Data triangulation involves collection of data from multiple sources with a similar focus to obtain diverse views of the phenomenon under study (Burns & Grove, 1997:241). Burns and Grove (1997:241) further identify different types of data triangulation as time, space and person triangulation of which the researcher used two.

- In this study, space triangulation was used as follows: Both government and private schools in the rural and the urban areas were used.

- Person triangulation was assured by using respondents with differences in age, educational level, religious denominations and place of residence (heterogeneity).

- A thorough literature review of different sources (books, articles, unpublished master's dissertation and doctoral theses) nationally and internationally was done.

4.10.2 Methodological triangulation

According to Burns and Grove (1997:242), method triangulation is the use of two or more research methods in a single study. There are two different types of method triangulation, of which the researcher used only one, namely across-method triangulation, which involves combining research strategies from two or more research traditions.

The methods were used sequentially to inform one another. A literature study was used as the basis for focus group interviews, which is a qualitative research strategy. The results of the focus group interviews were used to compile a questionnaire, which is a quantitative research strategy. The strengths and weaknesses of these methods complemented one another.

Other measures:

- Sampling methods used also increased the validity and the reliability of the study. Purposive sampling in focus groups enhanced understanding of the phenomenon. Random sampling of the participants for the questionnaire reduced or eliminated bias.

- Representativeness of the target population enhanced the validity and the reliability of the study.

4.11 DATA ANALYSIS

According to Burns and Grove (1997:53), data analysis is conducted to reduce, organize and give meaning to the data. Analysis of all data obtained was done at the nominal descriptive level. The Department of Biostatistics at the University of the Free State conducted the analysis.

The data analysis was done as follows:

- Close-ended questions were analysed, using the SAS computer programme. Descriptive statistics, namely frequencies and percentages for categorical data and medians and percentages for continuous data were used.

- Open-ended questions were analysed according to the method described by Tesch (cited in Creswell, 1994:155). This method is discussed under focus group interviews.

4.12 ETHICAL CONSIDERATIONS

The conduct of nursing research requires not only expertise and diligence, but also honesty and integrity (Burns & Grove, 1997:1955). According to Uys and Basson (1991:96), nursing research must not only be able to generate or refine knowledge, but the development and implementation of such research should be ethically, acceptable. Burns and Grove (1997:221) maintain that conducting research ethically requires protection of the human rights of the respondents. To honour these ethical codes the following ethical issues were taken into account:

4.12.1 Protection of human rights

According to Burns and Grove (1997:200:205), human rights that require protection in research include the following:

(i) Right to self-determination

This right is based on the ethical principle of respect for persons, which states that humans are capable of controlling their own destiny (Burns & Grove, 1997:200). To ensure that this right is protected, the researcher informed the prospective participants about the purpose of the study and how the findings would be utilized. They were allowed to voluntarily choose whether to participate or not. They were also informed that they had the right to withdraw from the study at any time without penalty and were assured that their school activities would not be affected.

(ii) Right to privacy

Privacy is the right an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others. The private information includes one's attitudes, beliefs, behaviour and opinions (Burns & Grove, 1997:203). This was protected by informing the participants that they were under no obligation to divulge private information.

(iii) Right to anonymity and confidentiality

The participant has the right to anonymity and the right to assume that the collected data will be kept confidential (Burns & Grove, 1997:204). To ensure this right, participants' names did not appear anywhere on the questionnaires, and study data were coded so they would not be linked to the participants. All study data were collected by the researcher and kept in a safe place, to which only the researcher had access. Members of the focus groups were requested to sign a statement of confidentiality (see Addendum H) according to which they agreed that they would not communicate the information discussed

during the interview to anybody other than their fellow group members. Signed consent forms were not stapled to the data collection instruments.

(iv) Right to fair treatment

This is based on the ethical principle of justice. In research, the selection of subjects and their treatment during the course of study should be fair (Burns & Grove, 1997:2055). Probability sampling method was used to select participants for the questionnaire, while purposive sampling method was used in the focus groups. All of them were selected only for reasons directly related to the research problem.

4.12.2 Obtaining informed consent

The essential information about the study regarding the purpose of the study, the method of data collection, and how the study findings would be used, were given to the prospective participants after which the written consent was obtained from the participants and the parents of the girls under 18 years (see Addenda F and G).

4.12.3 Permission obtained from formal gatekeepers

Permission to conduct the study was requested from and granted by the Ethics Committee of the Faculty of Health Sciences at the University of the Free State, the Ministry of Health and Social Welfare in Lesotho, as well as the Ministry of Education before the data collection (see Addenda A, B, C, D and I).

4.12.4 The quality of the research

According to Uys and Basson (1991:97) the researcher should always apply the highest possible standards in respect of the planning and implementation of research. To comply with this ethical standard, the researcher approached the project with integrity and ensured that her personal biases and values that could interfere with the results, were eliminated. The research protocol was submitted to the expert and evaluation committees for their expert view and ensure good quality planning before data collection commenced. According to the procedures of the School of Nursing at the UFS, the expert committee assess the feasibility of the study and the evaluation committee ensure appropriate methodology. In the literature study, arguments which were for and against the conceptual framework were included.

4.13 PROBLEMS ENCOUNTERED

Generally the data collection process went fairly smoothly due to the prior arrangements made by the researcher. However, there were a few problems experienced before and during data collection. They are the following:

- The Ministry of Education was reluctant to give permission to conduct the study due to the sensitivity of the topic. This delayed the commencement of data collection by two months.

- Data collection took place from September to October towards the end of the year examinations, so it was difficult to access students.

- September is also the time for payment of school fees and some of the students who were selected for the study were sent home for non-payment, therefore they had to be replaced by taking the next number on the register.

- Four schools did not agree to the proposed dates for data collection and gave their own dates after the scheduled period. This extended data collection by one week.

- In one of the school more students wanted to participate in the study, even though they had not been selected, including boys. They thought that there was a potential benefit from participation, but they were eventually persuaded to leave the hall.

4.14 SUMMARY

A non-experimental exploratory and descriptive design was used. The questionnaire was used as the data collecting instrument. The validity and the reliability of the questionnaire, as well as of the whole study, were ensured. The ethical considerations were adhered to. The results of the data analysis will be discussed in Chapter 5.

CHAPTER 5

Data analysis

5.1 INTRODUCTION

The purpose of data analysis, regardless of the type of data, is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research report (Polit & Hungler, 1991:500). It consists of three activities, namely the reduction, categorization and interpretation of data (Treece & Treece, 1986:50). In this study analysis was done according to descriptive statistics on a nominal level.

5.2 THE REDUCTION OF DATA

Data reduction involves focusing, simplifying and transforming raw data into a more manageable form (Berg, 2001:35). The qualitative data obtained through open-ended questions were reduced so that it could be presented in a logical and simple way. The qualitative analysis methods described by Tesch (cited in Creswell, 1994:155) were used (see description in Chapter 3). The quantitative data obtained through close-ended questions were analysed to form grouped frequency distributions.

5.3 THE ANALYSIS OF THE COLLECTED DATA

The results of data obtained by means of the questionnaire will be discussed in the same order as in the questionnaire (see Addendum K) under the following headings:

- Demographic data
- Knowledge about contraceptives
- Kwowledge about contraceptive/family planning services
- Sexual behaviour and attitudes towards contraceptives.

5.3.1 The demographic data

➲ *Age*

The minimum age of the respondents was 13 years and the maximum was 21 years. The median age was 16 years (75 percentite = 17 years and 25 percentite = 15 years).

➲ *Place of residence*

Out of 969 respondents, 564 (58.20%) resided in the urban and the rest in the rural area.

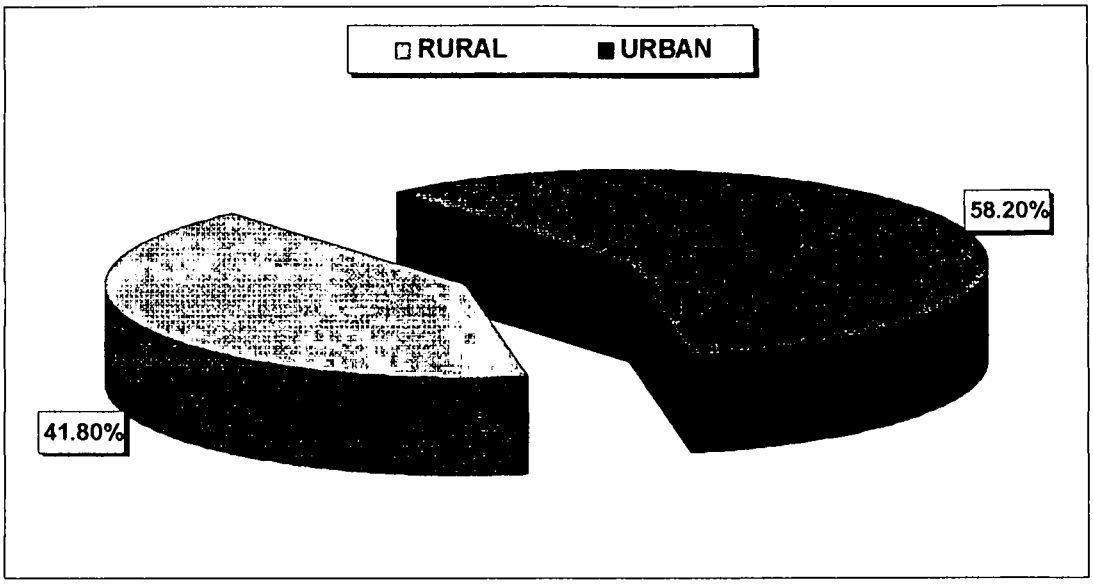

FIGURE 5.1: Distribution of respondents by residence (N=969)

➲ *Religious denomination of the respondents*

The religious denominations of the respondents are illustrated in Table 4.1.

TABLE 5.1: Religious denominations of respondents (N=969)

RELIGIOUS DENOMINATION	Frequency	Percentage %
Roman Catholic	426	43.97
Lesotho Evangelical Church	312	32.20
Anglican Church	87	8.98
Methodist	20	2.06
Seventh Day Adventist	14	1.44
Other	110	11.35
Total	**969**	**100**

- ***Educational level of the respondents is reflected in Table 5.2***

TABLE 5.2: Educational level of respondents (N=950)

EDUCATIONAL LEVEL	Frequency	Percentage %
Form A (Grade 8)	234	24.63
Form B (Grade 9)	259	27.26
Form C (Grade 10)	126	13.26
Form D (Grade 11)	199	20.95
Form E (Grade 12)	132	13.89
Total	**950**	**100**

5.3.2 Knowledge of contraceptives

(1) The respondents were asked how often they heard about contraceptive services

The results are reflected in Table 5.3 in order of freqeuency.

TABLE 5.3: Heard about contraceptives (N=944)

RESPONSES	Frequency	Percentage %
Every day	472	50.00
Once a month	175	18.54
Once a week	150	15.89
Never	147	15.57
Total	**944**	**100**

According to Table 5.3, half of the respondents (50%) heard about contraceptives every day; 18.54% heard about them once a month; 15.89% once a week; and 15.57% never heard of them.

(2) Methods of contraceptives known

The respondents were allowed to mark more than one response. The best known method of contraception was the condom with 89.58%, followed by the pill with 67.80% and the injection with 62.23%. Loop, foam and other methods accounted for 31.37%, 3.20% and 4.23% respectively. The results are illustrated in Figure 5.2.

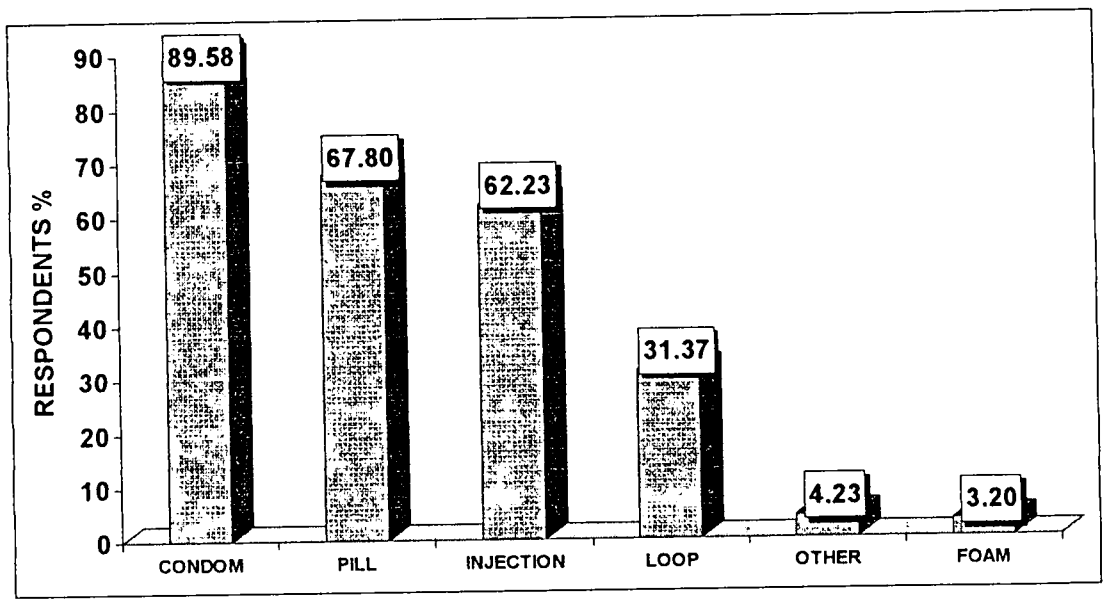

FIGURE 5.2: Methods of contraceptives known (N=969)

Other contraceptive methods specified are as follows:

- Diaphragm
- Norplants
- Abstinence
- Safe period
- Vinegar
- Jik
- Spirits (methylated)
- Withdrawal method

- Abortion
- Sterilization
- Rhythm method
- Traditional medicine
- Cook soda (bicarbonate of soda)

*(The part in brackets is the researcher's own explanation.)

(3) Methods available at the nearest clinic

This question addresses the knowledge of the adolescents regarding the available contraceptive methods. Nine-hundred sixty nine respondents answered the question and they were allowed to mark more than one response. The most available contraceptive method was the condom with 83.59%, followed by the pill with 62.02% and the injection with 55.93. The loop was 12.49% and the least available was the foam with 09.93%. Other available methods constituted 1.24%. The results are shown in Figure 5.3.

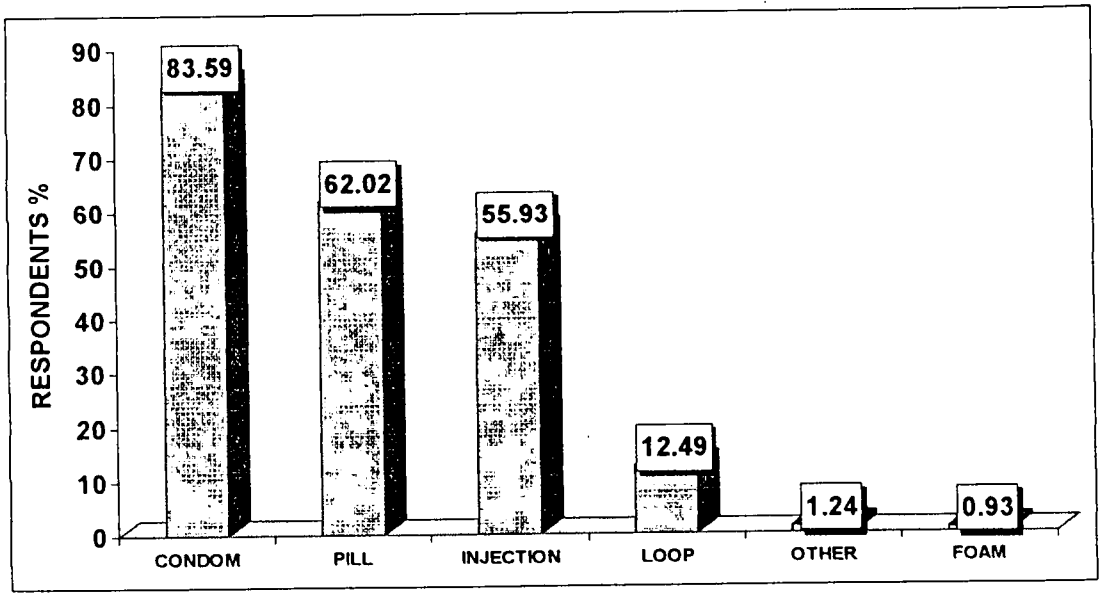

FIGURE 5.3: Adolescents' knowledge of contraceptive methods available at the clinics (N=969)

(4) Source of information regarding contraceptives

The question was answered by 969 respondents, and they were allowed to mark more than one response. The results revealed that parents were the main source of information with 52.94%, followed by the nurses with 49.12%, and teachers at 47.88%. Other role-players in informing adolescents in order of frequency are as follows: media 33.75%, peers 27.66%, literature 23.12% and boyfriend with 11.15%. Other sources make up 2.17%.

Other specified sources include:

- Sister
- Other relatives
- Priest
- Church minister.

(5) Whether contraceptives are for married couples only

Nine-hundred sixty seven responded to the question and 63.50% of the respondents did not think that contraceptives were for married couples only. The rest thought that they were meant for married couples only. The results are presented in Table 5.4.

TABLE 5.4: Contraceptives for married couples only (N=967)

RESPONSES	Frequency	Percentage %
Yes	353	36.50
No	614	63.50
Total	**967**	**100**

(6) Promiscuity, sterility, AIDS, weight loss and weight gain

The respondents were asked if they think that the use of contraceptives can cause promiscuity, sterility, AIDS, weight loss and weight gain. The results are presented in Table 5.5. NB: Not all the respondents gave answers to the subsections in this question.

TABLE 5.5: Problems associated with the use of contraceptives

PROMISCUITY (N=965)	Frequency	Percentage %
Yes	609	63.11
No	356	36.89
STERILITY (N=968)	**Frequency**	**Percentage %**
Yes	587	60.64
No	381	39.36
AIDS (N=965)	**Frequency**	**Percentage %**
Yes	452	46.84
No	513	53.16
WEIGHT LOSS (N=963)	**Frequency**	**Percentage %**
Yes	420	43.61
No	543	56.39
WEIGHT GAIN (N=963)	**Frequency**	**Percentage %**
Yes	329	34.16
No	634	65.85

(7) Whether contraceptives have other benefits besides pregnancy prevention (N=967)

45.92% of the respondents thought that contraceptives had other benefits, whereas 54.08% did not think so.

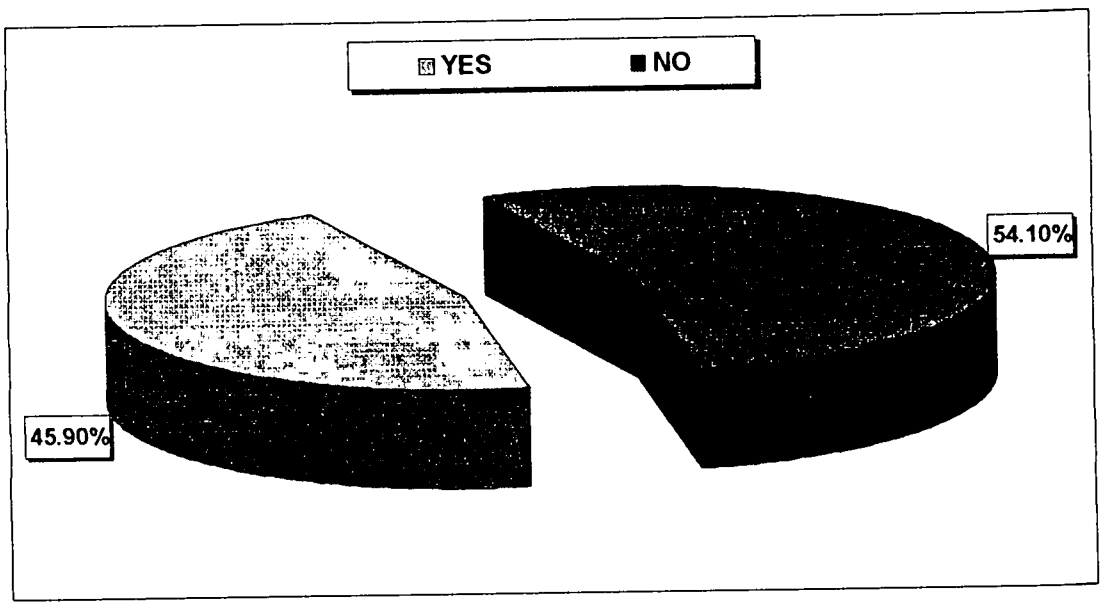

FIGURE 5.4: Views on benefits of contraceptives (N=967)

(8) Other benefits

Those who thought that contraceptives had other benefits were asked to mention them and the specified benefits are presented in Table 5.6.

TABLE 5.6: Specified benefits of contraceptives (N=349)

RESPONSES	Frequency	Percentage %
Prevent STI's and AIDS	326	93.40
Improve adolescent health and family life	7	2.01
Prevent over-population	5	1.43
One enjoys the relationship without fear	4	1.15
Reduce painful periods	2	0.57
Reduce sexual feelings (reduce libido)	2	0.57
Heal headaches	1	0.29
Clean blood resulting in good looking skin	1	0.29
Prevent death that may result from abortion	1	0.29
Total	**349**	**100**

According to Table 5.6, the most perceived benefit of contraceptives is the prevention of STI's and AIDS by 93.40%, followed by the improvement of adolescent health and family life which accounted for 2.01%, then the prevention of overpopulation with 1.43%, while helping one to enjoy the relationship without fear constituted 1.15%. Other benefits collectively accounted for 2.01%.

5.3.3 Knowledge of contraceptive/family planning services

(1) Service time at the nearest clinic

The results revealed that more than half of the respondents (55.03%) did not know the service time at their nearest clinics; 15.93% stated Monday to Friday 07:00-17:00; 13.84% Monday to Friday 08:00-15:00; 10.34% mentioned Monday to Friday 07:00-16:00; while the remaining 4.82% stated other times (see illustration in Figure 5.5).

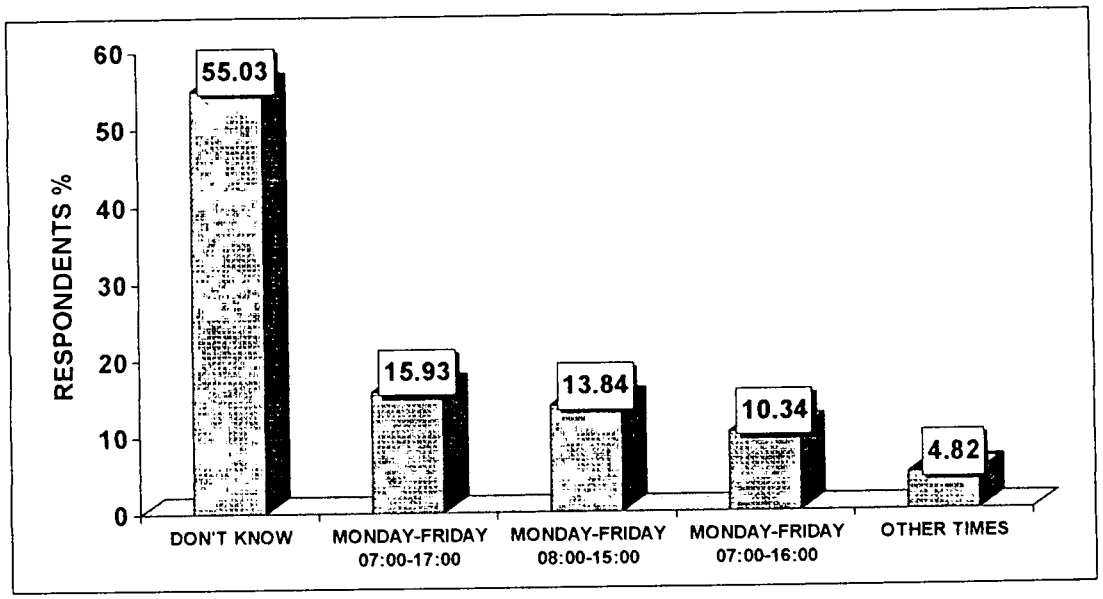

FIGURE 5.5: Perception of service time at the nearest clinics (N=954)

(2) Being able to get to the clinic during the service time

The results indicated that 35.12% never got to the clinic during the service time and 32.81% seldom did. The *"never"* and *"seldom"* cumulative percentage is 67.92%, 20.02% frequently did and 12.05% always got to the clinic during the service time. The responses are reflected in Figure 5.6.

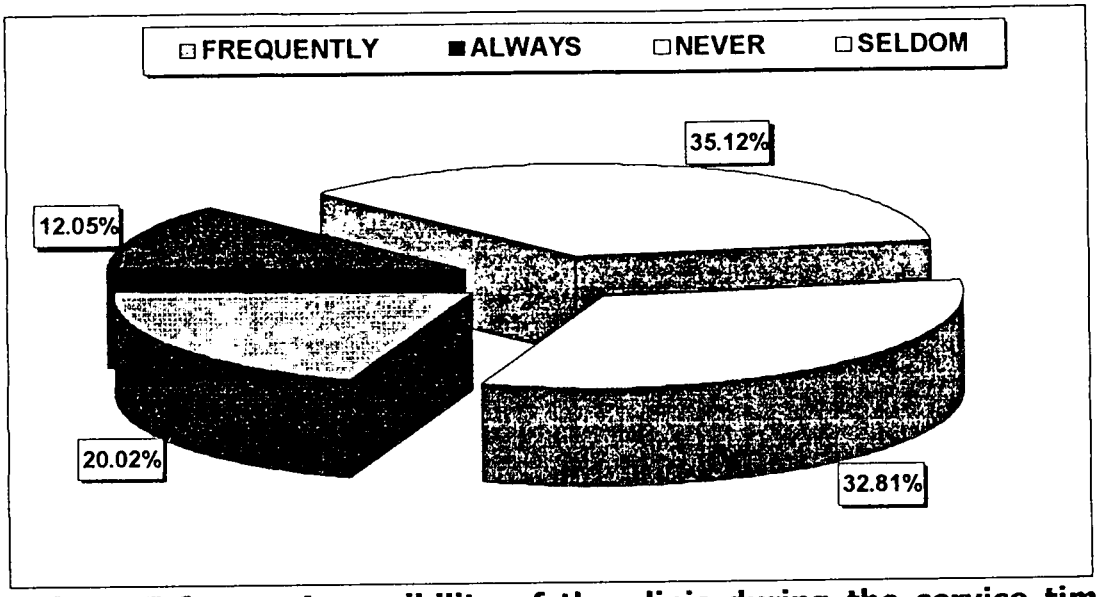

FIGURE 5.6: Accessibility of the clinic during the service time (N=954)

(3) Time taken to walk to the nearest clinic (N=954)

The minimum time taken was one minute and the maximum was 240 minutes with a median of 30 minutes (25 percentile = 20 minutes and 75 percentile = 45 minutes).

(4) Longest waiting time (N=826)

The minimum waiting time at the clinic was one minute while the maximum was 420 minutes. The median is 30 minutes (25 percentile = 15 minutes and 75 percentile = 60 minutes).

(5) Frequency of rendering contraceptive services at the nearest clinic

The results are presented in Table 5.7.

TABLE 5.7: The respondents' knowledge of frequency of rendering contraceptive services (N=962)

RESPONSES	Frequency	Percentage %
Don't know	715	74.32
Everyday	130	13.51
Once a month	65	6.76
Once a week	43	4.47
Other	9	0.94
Total	**962**	**100**

According to Table 5.7, most of the respondents (74.32%) did not know the frequency of rendering family planning services. The 13.51% indicated that they were rendered every day and 6.76% stated that the services were offered once a month.

(6) Whether nurses offered counselling on contraception to adolescents visiting the clinic for other reasons

The results revealed that only 14.35% received counselling during their visits to the clinic, while the majority of them (85.65%) did not. The responses are reflected in Table 5.8.

TABLE 5.8: Counselling on contraception (N=962)

RESPONSES	Frequency	Percentage %
Yes	138	14.35
No	824	85.65
Total	**962**	**100**

(7) Whether the respondents had heard of the patients' information leaking out of the clinic

The results are illustrated in Table 5.9.

TABLE 5.9: Confidentiality at the clinics (N=962)

RESPONSES	Frequency	Percentage %
Yes	137	14.24
No	825	85.76
Total	**962**	**100**

According to Table 5.9, only a small proportion (14.24%) had heard of patients' information leaking out while the majority (85.76%) had not.

(8) Ever gone to the clinic for family planning services?

The results revealed that only 40 (4.13%) had been to the clinic for family planning services and majority of the respondents (95.87%) had never been to the clinic for such services. The results are illustrated in Figure 5.7.

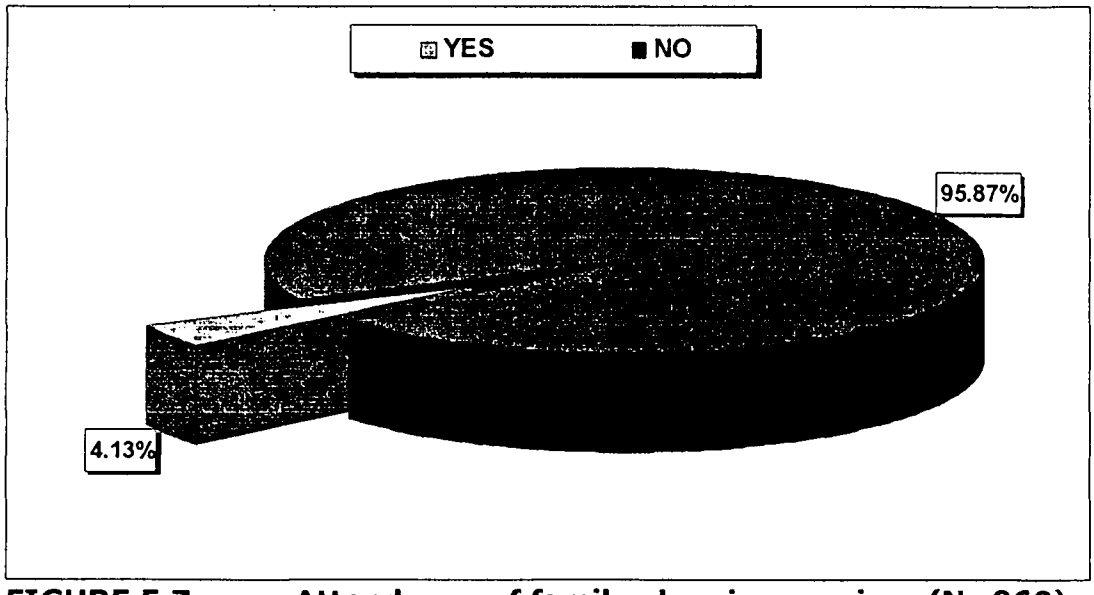

FIGURE 5.7: Attendance of family planning services (N=969)

(9) Whether those who had gone to the clinic for contraceptive services felt free to talk to the nurses about their family planning needs

The results indicated that 58.97% felt free to talk to the nurses, while 41.03% did not. The responses are reflected in Table 5.10.

TABLE 5.10: Freedom to talk to the nurses (N=39)

RESPONSES	Frequency	Percentage %
Yes	23	58.97
No	16	41.03
Total	**39**	**100**

(10) Reasons why they felt free to talk to the nurses (N=18)

Of the 18 who indicated that they felt free to talk to the nurses, the following reasons were given; 6 (33.33%) felt free, because they wanted to know about contraceptives, 5 (27.78%) stated that the nurses were friendly; 3 (16.67%) did not want to have babies, 2 (11.11%) were free, because that was how they lived nowadays. The remaining 2 (11.11%) felt that nurses are the only people who can help them.

(11) Reasons why they did not feel free to talk to the nurses (N=11)

The results revealed that majority of them (81.82%) did not feel free to talk to the nurses, because they were afraid and thought the nurses would judge them, while 18.18% did not intend going to the clinic, as they were taken by their mothers.

(12) Whether they felt comfortable to go for follow-up visits at the same clinic (N=37)

The results show that 67.57% of the adolescents who had gone to the clinic for family planning services felt comfortable to go for follow-up visits at the same clinics and 32.43% did not feel comfortable.

(13) Reasons stated for not feeling comfortable to go for follow-up visits (N=9)

The most commonly stated reason was that they felt embarrassed and afraid, which constituted 44.44%. The 22.22% did not want to use contraceptives any longer so there was no need to go back; and 11.11% went to the clinic just to get some information about contraceptives. The other 22.22% felt the nurses were not friendly. The results are illustrated in Figure 5.8.

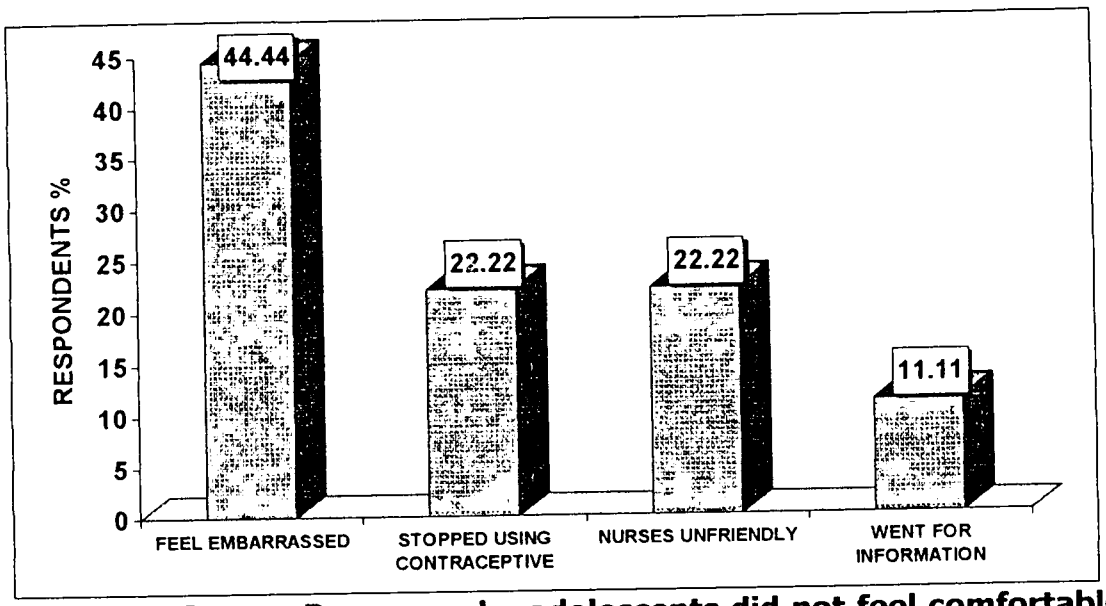

FIGURE 5.8: Reasons why adolescents did not feel comfortable about going for follow-up visits (N=9)

(14) Failed to obtain contraceptives due to lack of money (N=38)

For those who had been to the clinic for family planning services, the results indicated that only 13.16% had failed to obtain contraceptives due to lack of money, and the rest which is the majority (86.84%) had never experienced this problem.

(15) How adolescents thought they would be treated if they went to the clinic

The results are presented in Table 5.11.

TABLE 5.11: Adolescents' perception of the treatment at the clinics (N=951)

RESPONSES	Frequency	Percentage %
With respect	707	74.34
Would be insulted	158	16.62
Other	86	9.04
Total	**951**	**100**

5.3.4 Sexual behaviour and attitudes towards contraceptives

(1) Amount of control

The respondents were asked about the amount of control that they had when their boyfriends asked to have sex with them. The results are reflected in Figure 5.9.

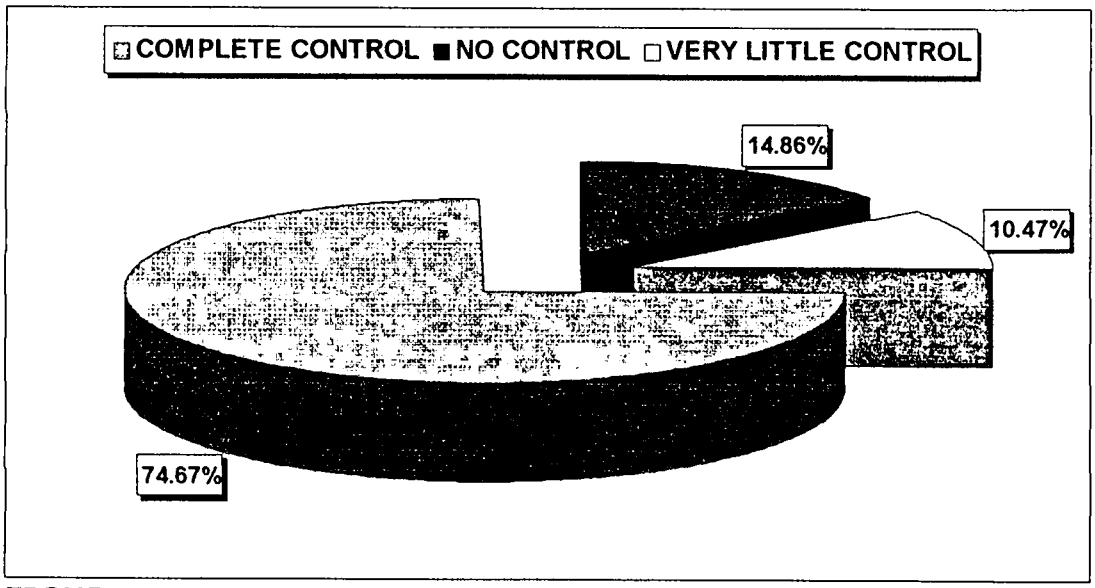

FIGURE 5.9: Amount of control when asked to have sex (N=945)

According to Figure 5.9, the results revealed that a cumulative of 25.29% had no control and little control, whereas 74.71% had complete control when asked to have sex.

(2) Regarding the reasons why girls engaged in sexual activity

The respondents were allowed to mark more than one response. The results indicated that 40.87% of the respondents thought that girls engaged in sexual activity to satisfy their sexual feelings while the majority (70.18%) did it to impress their boyfriends, 18.78% thought that sex was a sign of love, while most of them (62.02%) were pressurized by their boyfriends, whereas 43.14% did it for material/financial gain from the boyfriends. The 5.16% mentioned other reasons.

Other reasons specified are as follows:

- Peer pressure/to have something to say to the peers
- Desire to have children
- Rape
- To experiment according to what is seen on TV and magazines (pornography)
- To embarrass the parents

The results are illustrated in Figure 5.10.

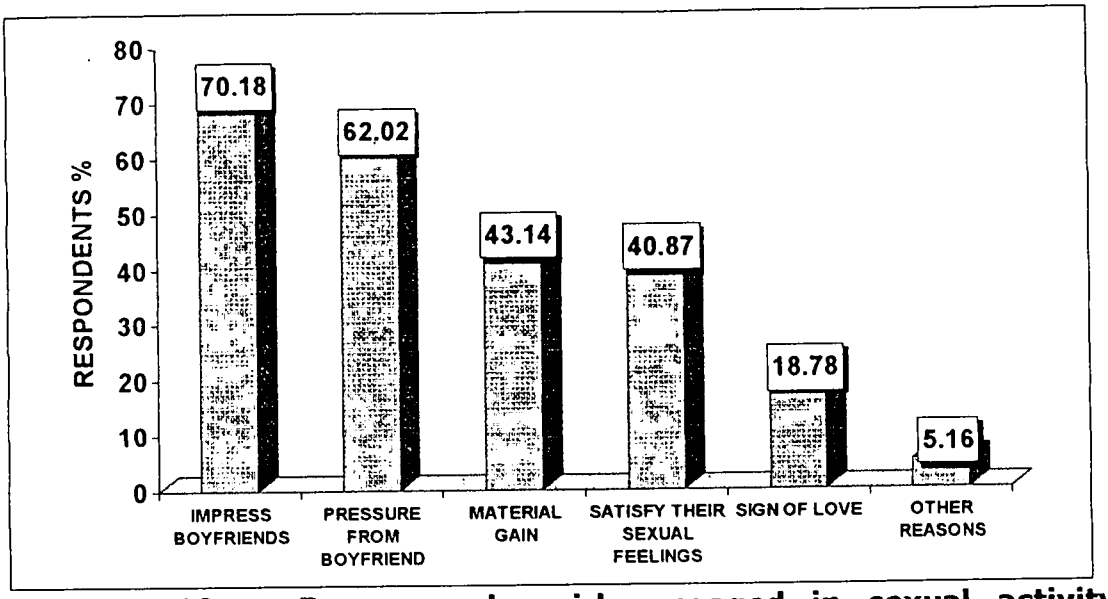

FIGURE 5.10: Reasons why girls engaged in sexual activity (N=969)

(3) Regarding what adolescents did to prevent unwanted pregnancies

The respondents were allowed to mark more than one response. The results indicated that most of the respondents (84.41%) abstained from sex; 20.53% used contraceptives, 20.22% waited for the safe period; while 1.03% performed abortions. Other measures accounted for 1.23%.

Other measures specified are as follows:

- Masturbation
- Oral sex
- Avoid having a boyfriend
- *"Don't know what to do."*

The responses are reflected in Figure 5.11.

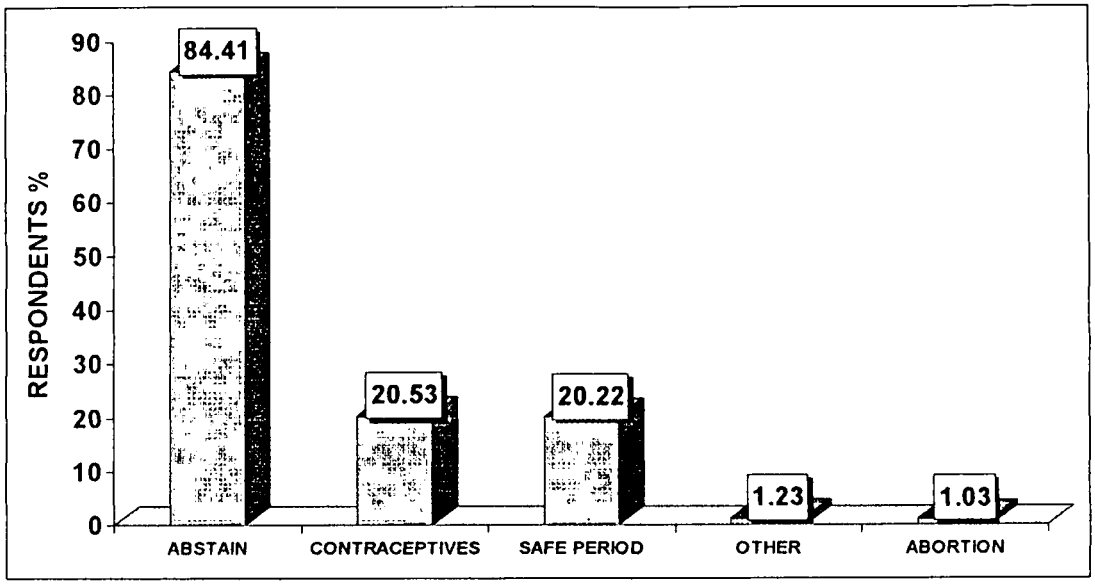

FIGURE 5.11: Measures to prevent unwanted pregnancy (N=969)

(4) Appropriate age to start using contraceptives (N=957)

The minimum age stated was nine years and the maximum was 65 years. The median was 21 years (25 percentile = 18 years and 75 percentile = 25 years).

(5) Concerning sexual activity (N=963)

The results revealed that 14.75% of the respondents were sexually active, whereas majority of them (85.25%) were not.

(6) Whether the respondents currently used contraceptives (N=968)

According to the results, only 13.02% of the respondents used contraceptives and most of them (86.98%) did not.

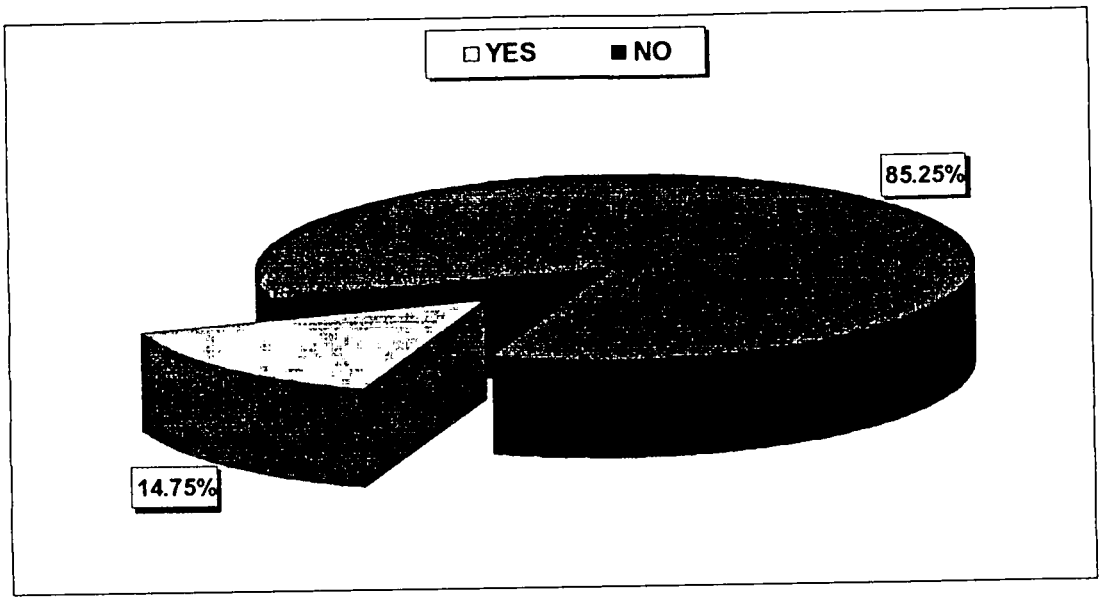

FIGURE 5.12: Adolescents' sexual activity

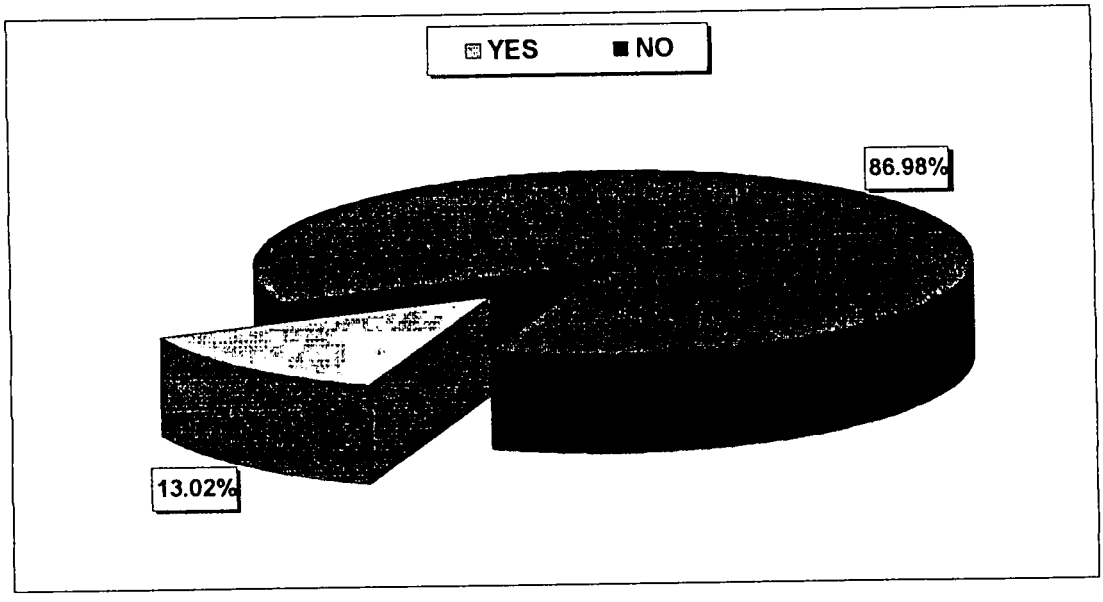

FIGURE 5.13: Adolescents' contraceptive use

The data on sexual activity and use of contraceptives are further broken down into categories.

TABLE 5.12: Breakdown of data on sexual activity and contraceptive use (N=969)

CATEGORY	Frequency	Percentage %
Sexually active and use contraceptives	88	9.08
Sexually active and don't use contraceptives	54	5.57
Not sexually active and use contraceptives	38	3.92
Not sexually active and don't use contraceptives	782	80.71
Sexual activity unknown and don't use contraceptives	6	0.62
Not sexually active and contraceptive use unknown	1	0.10
Total	**969**	**100**

According to Table 5.12, there were respondents who were sexually active, but did not use contraceptives (5.57%) and 3.92% were not sexually active, but used contraceptives.

(7) Those who were using contraceptives

They were asked what influenced their decision to use contraceptives. The respondents were allowed to mark more than one response. The results are presented in Table 5.13.

TABLE 5.13: Source of influence to use contraceptives (N=126)

RESPONSES	Frequency	Percentage %
Nurses	70	55.56
Boyfriends	61	48.41
Parents	50	39.68
Teachers	48	38.10
Media	40	31.37
Possibility of pregnancy that might result from rape	37	29.37
Peers	30	23.81
Religion	7	5.56
Other	7	5.56

(8) What influenced their decision not to use contraceptives

The respondents were asked what influenced their decision not to use contraceptives. They were allowed to mark more than one response. The results are reflected in Table 5.14.

TABLE 5.14: Source of influence not to use contraceptives (N=842)

RESPONSES	Frequency	Percentage %
Parents	544	64.61
Religion	259	30.76
Teachers	235	27.91
Culture	187	22.21
Nurses	147	17.46
Other	140	16.63
Peers	122	14.49
Boyfriends	119	14.13
Media	89	10.57

(9) Would they advise someone to use contraceptives

The results indicated that 451 respondents (46.64%) stated that they would advise someone to use contraceptives, while 516 (53.36%) would not. The responses are reflected in Figure 5.14.

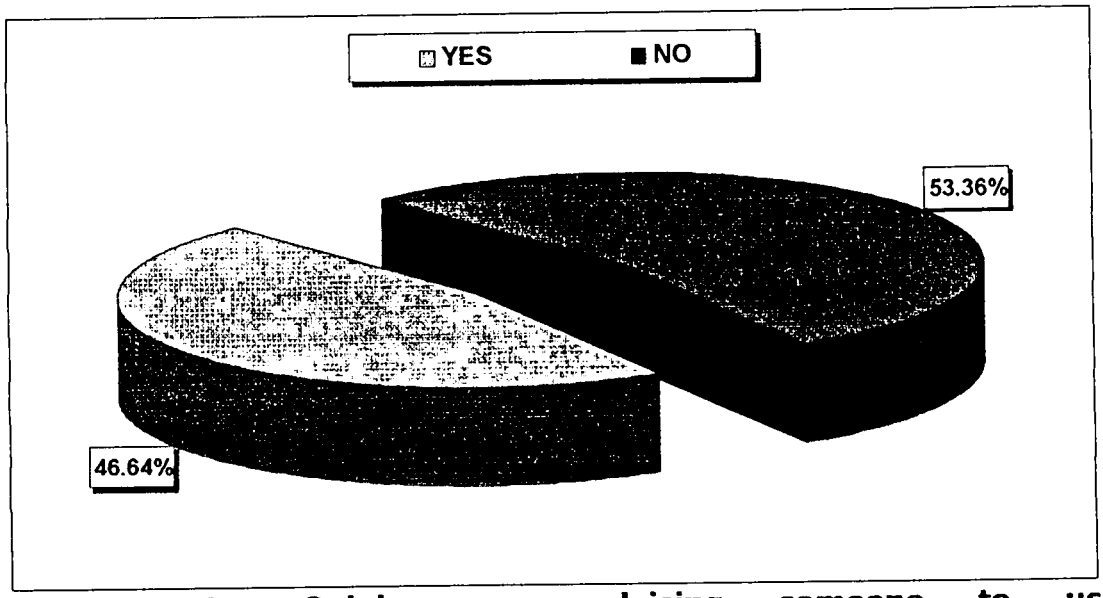

FIGURE 5.14: Opinions on advising someone to use contraceptives (N=967)

Different motivations were stated for advising someone to use contraceptives. The top five commonly stated reasons in order of frequency are as follows (N=451):

- Protection from unwanted pregnancy – 330 **(74.17%)**
- Prevention of HIV/AIDS and other STI's – 116 **(25.72%)**
- Protection in case of rape – 37 **(8.20%)**
- Contraceptives prevent overpopulation – 12 **(2.66%)**
- Contraceptives promote good health and better life – 6 **(1.33%).**

Motivations were also stated for not advising someone to use contraceptives. The top five commonly stated in order of frequency are (N=516):

- Premarital sex and contraceptives are culturally and religiously immoral – 159 **(30.42%)**
- Contraceptives cause illness, sterility and death – 123 **(23.84%)**
- Contraceptives cause promiscuity and increase AIDS – 82 **(15.89%)**
- Hate contraceptives – 51 **(9.88%)**
- People should make their own decisions – 36 **(6.98%).**

(10) Regarding the use of contraceptives to prevent pregnancy that might result from rape

The responses are presented in Figure 5.15.

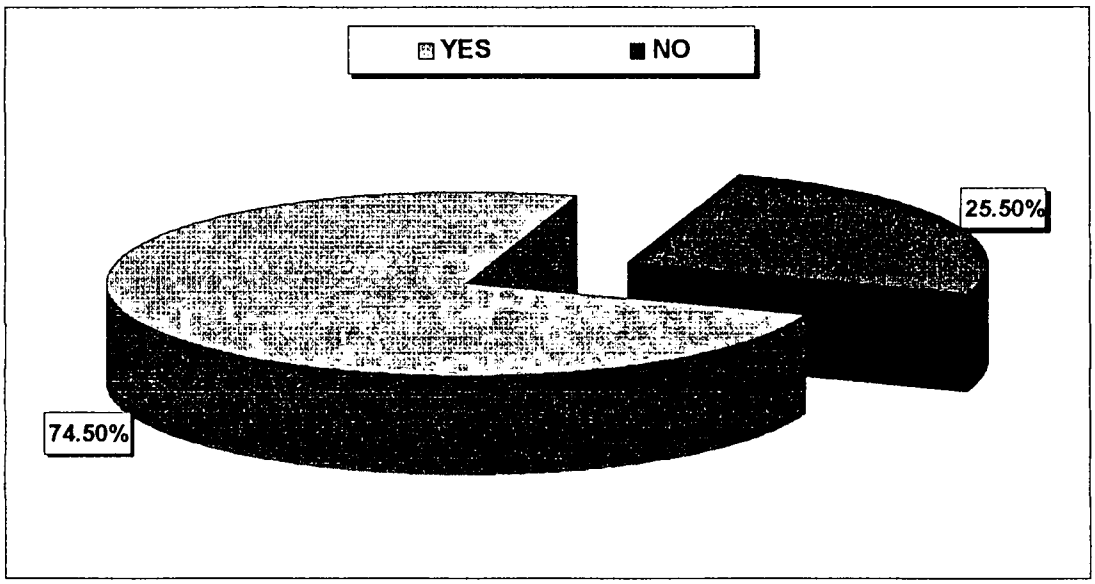

FIGURE 5.15: Opinions on the use of contraceptives to prevent pregnancy that might result from rape (N=953)

According to Figure 5.15, majority of the adolescents (74.50%) were of the opinion that contraceptives should be used to prevent pregnancy that might result from rape.

(11) Consequences of unplanned adolescent pregnancy

The respondents were allowed to mark more than one response. Results are reflected in Figure 5.16.

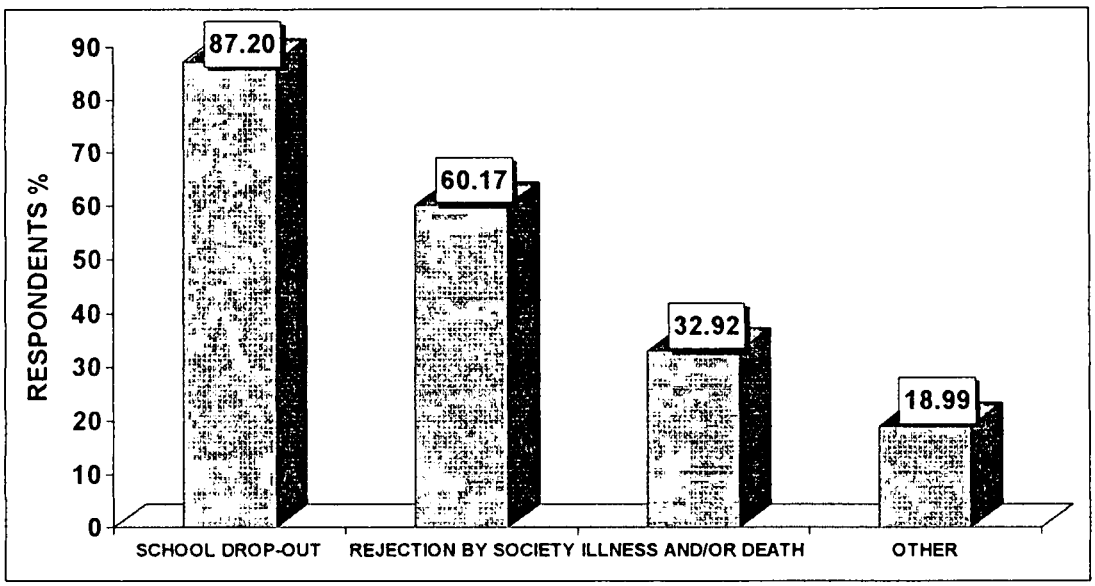

FIGURE 5.16: Percieved consequences of unplanned adolescent pregnancy

5.4 NON-RESPONDENTS

Although the non-response to the questions was not addressed in each question, some questions were omitted. The non-response rate per question varried from 0.10% to 14.75%. There was no specific pattern identified. For example, the non-response rate in sexual activity, which is more sensitive was 0.62%. A less sensitive question on the waiting time at the clinic had the highest non-response rate of 14.75%.

5.5 SUMMARY

In this chapter the analysis of the data obtained by means of the questionnaire was done. Analysis methods used to analyse qualitative and quantitative data were described. The responses were presented in figures and tables at a nominal descriptive level. Narrative discussions were also used to describe the responses. The findings of the study, conclusions and recommendations will be discussed in Chapter 6.

CHAPTER 6

Discussion of findings, conclusions and recommendations

6.1 INTRODUCTION

This chapter presents the discussion of the findings, which will be linked to the research objectives and the conceptual framework stated in Chapter 1. Conclusions will be drawn and the necessary recommendations made to improve utilization of contraceptive services.

Before examining the findings, it is important to understand that the use of contraceptives is a complicated multifaceted issue with many different aspects influencing one another. Although the findings are presented under specific headings it is only done in an attempt to structure the information and not to create boundaries among the different aspects.

6.2 DISCUSSION OF THE FINDINGS

6.2.1 Knowledge of contraceptives and misconceptions

This section will address adolescents' knowledge of the different types of contraceptives, sources of information and their misconceptions.

6.2.1.1 *Knowledge of contraceptives*

Generally adolescents displayed a high knowledge of the different types of contraceptives. Most of them knew about more than one method. The most commonly known methods are condoms (89.58%), pill (67.80%) and the injection (62.23%). The 20.54% knew only about condoms. This finding is in line with that of Silberschmidt and Rash (2001:1819) who found that almost all the girls in the study in Dar es Salaam knew of several types of contraceptives. It is apparent that condoms are widely known by all the participants. This could be attributed to the fact that condoms have two functions, namely the prevention of STI's and HIV/AIDS as well as protection from unwanted pregnancy.

6.2.1.2 *Sources of information*

Adolescents get their information about contraceptives from a number of sources. They include parents, nurses, teachers, peers, the media, literature and boyfriends. The results reveal that parents are the main source of information, as 52.94% of the respondents were informed by the parents and 64.61% indicated that their parents influenced their decision not to use contraceptives. Unfortunately, the content of the information given by the sources was not asked.

It is surprising that parents are the major role-players in informing adolescents about contraceptives. This could indicate a shift in traditional norms due to the following:

- Declining traditional structures which were used to educate adolescents about the prevention of pregnancy. Westernization and urbanization may be responsible for the decline.

- It may be possible that parents are beginning to realize the need to talk to their children about sex-related issues because they see an increasing number of pregnant adolescents and HIV/AIDS in their communities.

These findings add to the body of literature suggesting that parents may be the key agents in the promotion of communication about sex-related issues (Diclemente, Wingoed, Crosby, Cobb, Harrington & Davies, 2001:409). However, the findings contradict the focus group results, which revealed that there is a lack of communication between parents and their adolescent daughters. This is supported by Makatjane (1997:3) and Mturi (2001:21), who state that parents in Lesotho do not discuss sex-related matters with their children as these are is considered taboo subjects.

The results also revealed that 49.12% and 47.88% of the respondents received information from the nurses and the teachers respectively, while 55.56% indicated that nurses influenced their decision to use contraceptives. This is normal, since the nurses are the service providers. They are supposed to know the importance of contraceptives and advise adolescents to use them. Williams and Reddy (1998:33) and Mturi (2001:36) suggest that disseminating reproductive health information to the adolescents through nurses and teachers is a promising strategy, because they are knowledgeable

about these things and they are able to meet with large groups of people. In this way the dissemination of information will be facilitated.

6.2.1.3 Misconceptions regarding contraceptives

Although the respondents knew the types of contraceptives, they also had some misconceptions, e.g. 63.11% stated that they caused promiscuity; 60.64% indicated that they caused sterility; 46.84% claimed that they caused AIDS and 43.61% mentioned that they caused weight loss. These findings correlate with Otoide *et al.* (2001[a]:80), whose findings suggest that the use of contraceptives is a sign of promiscuity and that women who use contraceptives will not be able to conceive when they eventually get married.

The general perception that contraceptives cause AIDS is very serious. It undermines the whole HIV/AIDS prevention strategy and now the adolescents are doing precisely the opposite of what is required. This implies that they are not likely to use contraceptives for fear of contracting AIDS, looking at the rate of HIV infection which seems to be spreading like forest fire among the young people of Lesotho (MOHSW in Motlomelo & Sebatane, 1999:17).

These misconceptions may be due to lack of adequate knowledge and misinformation about contraceptives and can cause under-utilization of contraceptives.

Unfortunately the sources of the misconceptions are not known, which indicates a gap in the questionnaire, so it will be difficult to target the responsible persons with proper education and facts about AIDS, contraceptives and other sex-related matters.

6.2.2 Knowledge of contraceptive services

The results revealed poor levels of knowledge regarding the service time at adolescents' nearest clinics and the frequency of rendering the services.

More than half of the respondents (55.03%) did not know the service time at their nearest clinics and 74.32% did not know the frequency of rendering contraceptive services. These findings are consistent with those of Cromer and McCarthy (1999:297), who found that most of the adolescents in Great Britain and the United States seem to have poor levels of knowledge regarding family planning services.

There is more than one possible explanation for these findings:

- First, the clinics operate on weekdays during the day when most of the adolescents are at school.

- Second, premarital sex and the use of contraceptives are considered culturally immoral, so adolescents are likely to feel ashamed to go to the clinics to get information and/or services, as Mturi (2001:3) states that Basotho culture disapproves of all types of sexual relationships except within marriage.

- Third, it may be due to the negative attitudes of the service providers which discourage them from using such services (ICN, 1997:73).

- Last, it is possible that the health facilities do not advertise their services adequately to the adolescents.

6.2.3 Attitudes towards the use of contraceptives

The attitudes will be discussed under the age appropriateness; feelings about contraceptive use; use by married people only; and the importance of contraceptives, as well as the consequences of unplanned adolescent pregnancy.

The questions addressing the issue of attitudes were asked in different ways and were scattered throughout the questionnaire. The questionnaire was designed to elicit information from multiple perspectives.

There are many contradictions arising from the responses.

6.2.3.1 Appropriate age to start using contraceptives

The results indicate that adolescents had mixed feelings about this issue. The lowest ages stated are nine, 10 and 11, the reason being that girls engage in sexual activity at a very young age and also as a protective measure against unwanted pregnancy in case of rape. This finding is supported by the Centre for Reproductive Rights (2003:1 of 1), which states that young girls are confronted with sexual and reproductive issues as early as age 10 and they may become victims of rape.

On the other hand, some adolescents stated the highest ages of 50, 53, 56 and 65 and the motivation behind these is that they would have completed their families and there was no problem if they could not have children anymore. These reasons could indicate a misconception that contraceptives cause sterility. These could also show a lack of knowledge about the reproductive age, since there is no need to use contraceptives when a person has already reached menopause.

However, the median age was 21 (25 percentile = 18 and 75 percentile = 25 years).

6.2.3.2 Use of contraceptives by the adolescents

The respondents were asked if they would advise someone to use contraceptives and to motivate their responses. The question was not personalized to give them the freedom to state their views. The 53.36% indicated that they would not, because contraceptives were dangerous to the young girls' bodies. They insisted that their friends must abstain because sex before marriage is immoral. This is consistent with Motlomelo and Sebatane's findings (1999:54), who found that 74.4% indicated that sex before marriage is a bad thing and adolescents should not do it, so it would not be necessary to use contraceptives. Unfortunately the incidence of adolescents' pregnancy at 52.1% in Lesotho shows that abstinence is not being practised (MOHSW, 1997:1).

On the other hand 46.6% would gladly advise someone to use contraceptives due to the perceived benefits such as protection from unwanted pregnancy and in case of rape; prevention of HIV/AIDS and other STI's, preventing over population; and preparation for a better future. Although they acknowledged the importance of contraceptives, usage is generally low as only 13.02% of those who were sexually active (14.75% of the sample) reported using them.

6.2.3.3 Contraceptives for married couples

Some respondents (36.50%) thought that contraceptives were meant for married couples only. This could be attributed to the Basotho culture which does not allow premarital sex (Mturi, 2001:1). These findings are in line with what Silberschmidt and Rash (2001:1819) found concerning contraceptive behaviour, some adolescents did not know that they were entitled to use contraceptives. To their knowledge only women who had children were allowed at the family planning clinics.

Contradictory to the preceding paragraph, most of the respondents (63.50%) were of the opinion that contraceptives were meant for anybody who was sexually active, not married people only. However, the behaviour of the adolescents do not support the opinions they express, only 9.08% reported that they are sexually active and use contraceptives. Of note is that the prevalence of premarital sex is increasing in Lesotho, but disturbing is the fact that this is not accompanied by contraceptive use (Makatjane, 1997:12). These findings are similar to those in Ghana, as Agyei, Biritwum, Ashitey and Hill (2000:507) found that 89.6% of the female adolescents were in favour of the use of contraceptives before marriage, but only 25% of the sexually active adolescents were using them.

According to the cognitive dissonance theory this inconsistency is called attitude-discrepant behaviour (Taylor, Peplau & Sears, 2000:139). Dissonance is thought to create discomfort and a desire on the part of the individual to eliminate or reduce the inconsistency (Ivancevích & Matteson, 1996:128). This could mean adolescents changing their attitudes about the use of contraceptives before marriage or modifying their behaviour and consequently using contraceptives.

6.2.3.4 The importance of contraceptives and the consequences of unplanned adolescent pregnancy

The results reveal that adolescents were aware of the importance of contraceptives as state in 6.2.3.2. The majority (74.50%) felt that contraceptives could be used to prevent pregnancy that might result from rape, because the victims are mostly adolescents. Fekadu (2001:114) agrees that female adolescents are under threat from male advances often taking the form of rape.

Regarding the percieved consequences, the most common response was school drop out which accounted for 87.20%, followed by rejection of the adolescents by society with 60.17% and illness and/or death with 32.9%. Other consequences constituted 18.99% and they include destroyed future, suicide poverty and abortion. There was a gap in the questionnaire. The list of options under the consequences of unplanned adolescent pregnancy was too limited, as some of the important options such as poverty and abortion that appear in the literature were omitted, they were only specified by the respondents under other consequences.

6.2.4 Attitudes towards contraceptive services

The attitudes regarding the services were assessed through the different components of accessibility and will be discussed as such. Accessibility determines the user-friendliness of the services.

6.2.4.1 *Geographical accessibility*

Geographical accessibility was compared to the place of residence, because there is a tendency of long distance walk in the rural areas. Urban: 75 percentile = 40 minutes, 25 percentile = 20 minutes and the median = 30 minutes. Rural: 75 percentile = 60 minutes, 25 percentile = 20 minutes and the median = 30 minutes. Therefore there is no significant difference as confirmed by 95% confidence interval for the median difference [-10 : 0]. The results revealed that most of the clinics are geographically accessible. They are within walking distance and showed a median of 30 minutes' walk. (The WHO suggests five to 10 km.) A person walking at a normal pace can for example walk three km per hour. Therefore, a 30 minutes walk is well within the WHO limits.

6.2.4.2 *Financial accessibility*

The services are generally financially accessible, as only 13.16% indicated they had failed to obtain contraceptives due to lack of money compared to the 86.84% who had never experienced any financial problems. This is in line with what Tuoane (1999:238) found, namely that adolescents found contraceptive methods cheaper, particularly condoms. They further maintain that the cost of contraceptives is far cheaper than the cost of raising a child. The cost of oral contraceptives is M5.00 for a three months supply. The same price applies to injectables. Condoms are free.

6.2.4.3 *Functional accessibility*

The results indicated that 74.34% of the respondents thought that the nurses would treat them with respect if they went to the clinics, while only 16.61% thought that they would be insulted. Adolescents had a very low experience

of family planning services, as only 4.13% had been to the clinic for such services, so it must be remembered that these are perceptions.

Although the services are available and affordable, most of the respondents were not able to get to the clinic during the service time. The cumulative percentage of 67.92% experienced this problem, making the service functionally inaccessible to the adolescents.

6.2.4.4 Cultural accessibility

Adolescents and health service providers belong to the same culture and it is likely to influence their attitudes during service provision and seeking of the services. Therefore cultural accessibility will be looked at from the adolescents' and the service providers' perspectives.

- ***Adolescents***

Adolescents feel embarrassed to go for contraceptive services and think that they will be humiliated for being sexually active. This attitude could be influenced by their culture which states clearly that premarital sex is not acceptable (Mturi, 2001:1). These findings are in keeping with those of Cromer and McCarthy (1999:292) who found that adolescents are ashamed of being seen at family planning clinics. This could explain the 95.87% of the respondents who had never gone to the clinic for family planning services.

- ***Health service providers***

The service providers could use their cultural values to judge the adolescents who seek contraceptive services. Because of their morals, they could discourage them from using the services, or think that those who are using

contraceptives are promiscuous. They might also be reluctant to provide the services to the adolescents for fear of parental reaction (Cromer & McCarthy, 1999:293).

6.2.5 *Sexual activity and the use of contraceptives*

Adolescents' sexual activity and the use of contraceptives prompted this study and the findings on these topics will be discussed under one section, because they seem to be intertwined.

6.2.5.1 Sexual activity

There were 14.75% of the respondents who indicated they were sexually active and the rest, which is the majority, were not. This raises a good deal of concern, because it may not be a true picture of reality, considering the incidence of adolescent pregnancy in Lesotho, which was reported as 52.1% (MOHSW, 1997:1). There might have been some of the respondents who gave questionable responses, because they knew that premarital sex is culturally unacceptable, or they simply did not feel comfortable enough to be open.

Of those who were sexually active, 26.06% were younger than 16 years and 73.94% were older. This view is in line with Motlomelo and Sebatane's findings (1999:2) who found that some female adolescents engage in sexual activity as early as 13 years.

The 58.45% of the sexually active adolescents resided in the urban area, while the rest were in the rural area. The place of residence played no significant role regarding the difference in the sexual activity of the respondents.

The respondents who were sexually active, were in all the standards from Form A (Grade 8) to Form E (Grade 12). The lowest percentage was in Form A with 10.14% and increased with the level of education up to Form E with 33.33%.

6.2.5.2 Use of contraceptives and contraceptive services

The results revealed that 13.02% of the respondents used contraceptives and only 4.13% reported using contraceptive services. This is in line with Olowu's findings (1998:49) who found that only 2% of the adolescents in Nigeria were utilizing family planning services. Contrary to these findings, South African Demographic and Health Survey (SADHS) (1998:1 of 2) found that contraceptive use is quite high among all adolescents in South Africa, especially those who are sexually active. More than one in every four adolescents are currently using contraceptives.

Of those who were using contraceptives, 33.33% were under 16 years and 66.67% were older, 61.90% resided in the urban area, while 38.09% were in the rural area. Their use of contraceptives was high in Form E (30.08%). These findings agree with those of the CDC (1999:47) who suggests that the use of contraceptives is high among educated adolescents living in the urban areas.

The low use of contraceptives and contraceptive services could be attributed to the following factors:

- ***Cultural barriers***

The Basotho culture disapproves of premarital sex and any sex-related issues except within marriage (Mturi, 2001:1). This is also true in other parts of Africa (Otoide *et al.*, 2001[b]:298). Owing to these barriers, adolescents may feel inhibited and uncomfortable to go for contraceptive services, as they are ashamed of being seen by their elders at the family planning clinics.

Adolescents may also face serious cultural barriers from the service providers who have strong moral objections to offer them the services they are entitled to. This kind of behaviour could prevent adolescents from using contraceptives and contraceptive services. This is supported by Silberschmidt and Rash (2001:1819), who found that only two 16-year-old girls received contraceptives during a one-year period, and they were prostitutes according to the judgement of the nurse. The ICN (1997:73) agrees that, by demeaning the adolescents for their lifestyle, the service providers unintentionally discourage them from using such services.

Although a smaller percentage of 22.22% had reported judgemental attitudes of the service providers, it could be due to the fact that only 4.13% of the total population had used contraceptive services. However, it came out in the literature and focus groups and therefore cannot be ignored.

- ***Gender-power imbalances***

Most of the girls are under a lot of pressure from their boyfriends/sexual partners who want to have sex with them. Two questions were asked to determine if the female adolescents were willing participants when they engaged in sexual activity. The first question was personal:

- **How much control do you have if your boyfriend asks you to have sex with him?**

The second question was more general:

- **Why do you think girls engage in sexual activity?**

In the first question 74.71% stated that they had complete control, while 14.81% had no control and 10.48% had very little control.

The results of the second question contradict those of the first question. The 70.18% engaged in sexual activity to impress their boyfriends and 62.02% did it because of pressure from their boyfriends. This is in agreement with the socio-cultural norms in Lesotho which allow men to dominate women in most spheres of their lives including their sexual behaviour (MOHSW, 2000:19). When faced with the decision to either protect oneself from unwanted pregnancy or satisfying a sexual partner by putting oneself at risk of an unwanted pregnancy, it appears some girls would opt for the latter. Maybe this pressure explains why 74.50% of the respondents thought that it was necessary to use contraceptives to prevent pregnancy that might result from rape.

- ***Lack of adolescent-friendly health services***

Although the services are geographically and financially accessible to the adolescents, they do not adhere to all the principles of an adolescent-friendly service. The reasons are as follows:

- The service time is not convenient for the adolescents, because the clinics operate on weekdays during the day when most of the adolescents are at school and 67.92% never and seldom reached the clinic during the service time.

- There is lack of counselling services provided to the adolescents during their visits to the clinics for some reasons other than contraceptive services. Only 14.35% of the respondents received counselling on contraception.

- The judgemental attitudes of the service providers towards adolescents' use of contraceptive services can have a negative influence on the utilization of such services, as 22.22% indicated they had experienced this problem.

Owing to the above-mentioned factors adolescents may not feel free to use the services.

6.3 CONCLUSIONS

A lot of contradictory information emerged from the adolescents' responses. It might be an indication of the confusion they are experiencing due to the internal and external forces impacting on their lives. Adolescence is typicaly a stage of confusion (Abebe, 2001:98).

Based on the discussion of the findings the following conclusions were drawn:

6.3.1 There is inadequate knowledge of reproductive health and contraceptives

- Lack of knowledge can be a source of confusion and adolescents will not be able to make informed decisions.

6.3.2 Adolescents have misconceptions regarding contraceptives

- Misconceptions can have a negative impact on the utilization of contraceptives.

6.3.3 There is lack of knowledge regarding contraceptive services

- Most of the adolescents have no idea of what is happening at the clinics, possibly there is little or no publicity of the services, so it may not be easy for them to utilize the services.

6.3.4 Adolescents have contradictory attitudes towards the use of contraceptives

- The results showed mixed feelings about this issue and 53.36% felt that contraceptives should not be used, because they were perceived to be dangerous. Because premarital sex is not acceptable, 84.4% advocated for abstinence.

- On the other hand, 63.50% thought that contraceptives were good and should be used by anybody who is sexually active, married or not.

6.3.5 There is lack of adolescent-friendly health services

- The service time is not convenient and flexible to accommodate the adolescents after school or during the weekends.

- Some of the service providers are judgemental when providing contraceptive services to the adolescents, as 22.22% experienced this problem.

- There is lack of counselling provided on contraception to the adolescents going to the clinic for other reasons.

6.3.6 A discrepancy exists between sexual behaviour and the use of contraceptives

- The results revealed that 14.75% of the respondents were sexually active and 13.02% used contraceptives.

- Of those who were sexually active, only 9.08% used contraceptives.

- The 5.57% stated that they were sexually active, but they were not using contraceptives. This is a source of concern for the researcher because they are at risk of getting pregnant.

- There is yet another group (3.92%), who were not sexually active and used contraceptives. These adolescents may actually be indulging in sex or if not, they might be taking precautions in case of rape, as 74.50% of the respondents had already indicated the need to use contraceptives for this purpose. There is another possible explanation, contraceptives are also used for therapeutic purposes. It might be the case with these adolescents, but it was not provided for in the questionnaire, which indicates a gap.

6.3.7 There is under-utilization of contraceptives and contraceptive services

- The results confirmed the problem of under-utilization of contraceptives and contraceptive services by sexually active adolescents. This is due to lack of adequate knowledge of contraceptives resulting in misconceptions. Unfriendly adolescent health services are also contributing to this problem. Cultural barriers an d gender-power imbalances have been identified as the inhibiting factors to the use of contraceptives.

6.4 RECOMMENDATIONS

In the light of the conclusions reached, the following recommendations are made:

6.4.1 Empower adolescents with knowledge

Knowledge is the key to adolescents' good health and a better future and they voice their need for information. The following excerpt is an example of the problems they face as a result of ignorance: It comes from a young girl in Ireland who became pregnant:

> ***"I was an immature girl, who because I got pregnant was meant to behave like a woman. Suddenly I came from being a schoolgirl to being a mother. I wasn't wild, I hadn't even lived – I had hardly been allowed out to discos. I felt that my sex education was inadequate. I believed stupid things. I thought it happened to one in every family and because it happened to my sister, it couldn't happen to me"*** **(WHO, 1999:57).**

- To prevent this and similar problems, nurses, parents and teachers should join hands to educate adolescents about reproductive health matters.

- To ensure that they speak in one voice, parents and teachers should be educated about growth and development at different stages and be given factual information about reproductive health. Teachers should receive the information as part of their curriculum during their training. Parents should be educated in small manageable groups in the villages or at the nearest clinics.

- Parents should start talking to the children while they are still young, beginning with the general issues appropriate for their age and introducing basic anatomy and physiology as they grow older.

- When sex education has been established, the teachers will teach according to the curriculum, re-inforcing what they have already discussed with the parents, or giving them new information depending on the situation.

- The nurses will also educate them about the same topics and make sure that their health education corresponds with the level of education of the adolescents. It is critical for the nurse to stress reproductive health. When talking about contraceptives, it is important for them to know about the different types, mode of action and the side effects.

- Informal programmes could be established using the existing youth groups like church groups, sports clubs and other organized groups in the communities. Under the supervision of a health service provider the programmes could create awareness on issues that receive little attention at home or at school. Teaching and learning methods that are acceptable to the adolescents could be used, for example discussions, debates etc.

- It is only when adolescents know the facts about reproductive health and contraceptives that the misconceptions they harbour will be corrected and their fears will be allayed.

- ***Educate adolescents to adopt a more assertive attitude***

When adolescents are equipped with assertiveness skills, they will be able to stand up for their own legitimate rights. They should be educated regarding gender equality. This knowledge will help them understand that their boyfriends are not decision-makers but partners in a love relationship. They must learn to say *"No"* to sex if they are not willing.

However, it would be important to involve males in the informal discussions considering the role they play in the reproductive health of their female counterparts. These joint discussions could be an eye opener to both boys and girls, and in the end they would be able to understand and respect one another.

6.4.2 Correct misconceptions

There is a need to correct misconceptions to clear the confusion that was observed in this study. This can be achieved by means of information and education as stated in 6.4.1. These measures could also eliminate or reduce the discrepancy between sexual activity and the use of contraceptives.

6.4.3 Advertise contraceptive services

Health facilities should market the services for the consumers. They must state the types of services rendered, the time of service, and the cost. The mass media should be used. The radio would be more effective because most families own radios. Posters could also provide good publicity. The television

might also be used, but most of the families do not possess them, especially in the rural areas.

6.4.4 Create adolescent-friendly health services

The success of an adolescent-friendly health service will depend on how well the service providers manage the adolescents. The aim is to provide appropriate care and reduce barriers. This can be achieved with minor changes in the existing health services and nurses have a major role to play.

- Counselling must be provided to adolescents seeking contraceptive services and nurses must grab the opportunity when adolescents attend the health services for other reasons.

- The service time could be made flexible to accommodate adolescents after school. The closing time could for example be extended from 16:00 to 17:00 every Wednesday, or they could open on Saturdays from 09:00 to 12:00.

- Education of the health service providers is needed. They should be educated on the importance of the reproductive health of adolescents, including contraceptive services. Regular in-service training is required to keep up with the latest developments in adolescent health. The service providers must be warned against letting their personal values and morals influence their judgement. What is acceptable to them may not be acceptable to the adolescents.

6.4.5 There is a need to improve the utilization of contraceptives and contraceptive services by the adolescents

It is the responsibility of the health service providers, especially nurses, to improve the utilization of these services. Adolescents must have access to information, education and counselling concerning contraceptives and other reproductive health matters so that they can be able to make informed decisions.

It was stated at the beginning of this chapter that the findings are interrelated and influence one another. They all have an impact on the use of contraceptives and contraceptive services, so the implementation of all the above stated recommendations will improve the utilization of these services.

6.5 POLICY IMPLICATIONS

The Ministry of Health and Social Welfare in Lesotho is in the process of developing a Reproductive Health Policy. In the absence of this policy, there are no guidelines for the service providers, which implies that they use their own discretion. This could be hindering the provision of effective reproductive health services in the country. It is important for the Ministry to finalise the policy.

The Government is planning to establish sex education in the school curriculum in Lesotho. The Ministries of Health and Education are supposed to be the stakeholders in this issue, but there could be an indication that the Ministry of Education is not yet sensitised, for example it was reluctant to give permission to conduct this study, stating that the topic was sensitive. Permission was granted after three months following a good deal of

consultations. The government should create awareness about reproductive health among all the Ministries.

6.6 IMPLICATIONS FOR FURTHER RESEARCH

- The study concentrated on the female adolescents as the consumers of health care, and the attitudes of the service providers have not been explored. Therefore there is a need to determine the attitudes of the service providers about the provision of adolescent reproductive health services particularly contraceptive services.

- This study revealed the importance of male involvement in the reproductive health of their female counterparts. Whereas male adolescents could be facing similar reproductive health problems, the study was limited to the female adolescents. Therefore further research is needed to assess the knowledge and attitudes of the male adolescents regarding the use of contraceptive services. According to Bergstrom (cited in Phoofolo, 2002:1), men do not only have reproductive health concerns of their own, but their health status and behaviours also affect those of their partners as well.

- Parents have a duty to raise their children to become healthy responsible adults. Further research is needed to:

  - determine the extent of parents' involvement in the reproductive health education of their adolescent children;

  - assess the impact of adolescent pregnancy on the family; and

- assess the knowledge of the parents regarding reproductive health.

➢ Teachers can disseminate information to large groups of people. Research is therefore needed to assess teachers' knowledge of the reproductive health.

➢ The report of the study will be handed to the Ministry of Health. Recommendations were made to improve the utilization of contraceptive services. Further research is needed to:

- assess the effectiveness of health services in rendering adolescent-friendly health services; and

- assess the impact of increased knowledge with regard to the use of contraceptives.

6.7 LIMITATIONS OF THE STUDY

➢ Two schools did not give the researcher access to the students and this reduced the proposed sample size from 1,000 to 969. It was reduced by 0.3% and it did not have a significant impact on the study.

➢ Although the researcher collected data on the same date in schools which are in close proximity to one another, there was a possibility of contamination of future respondents, because the data collection process took four weeks, since the researcher did not have field workers to assist her.

- The participants were drawn from the schools only, adolescents who are out of school were excluded and the sample could be biased.

- There were some gaps in the questionnaire:

  - The content of the information received from the different sources about contraceptives was not requested. It could be factual and objective, or inaccurate and subjective information.

  - The sources of the misconceptions were not asked, so it would be difficult to target the responsible people with proper education.

  - In the question regarding the consequences of unplanned adolescent pregnancy, the list of responses was too limited and the serious options such as poverty and abortion that appear in the literature, were omitted.

  - There was no question on the other options where contraceptives can be obtained.

  - The literature indicated that the RCC clinics do not offer modern contraceptives, but there was no question with regard to the ownership of the clinics.

  - The missing questions in the questionnaire could have given more strength to the study.

- Although the researcher was present during the completion of the questionnaires, the problem of missing information/unanswered questions was identified in some questions.

6.8 SUMMARY

In this chapter the findings of the study were discussed and the conclusions were drawn from the findings. Recommendations to improve the utilization of contraceptives and contraceptive services were made. Policy implications and implications for further research were highlighted. Finally, the limitations of the study were indicated.

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ADDENDUM A

Letter requesting permission to conduct the study to the Ministry of Health

Ha Makhoathi
P.O. Box 12422
MASERU
100

17th April, 2002

The Director of Health Services
Ministry of Health and Social Welfare
MASERU
100

Dear Sir

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, hereby, request permission to conduct research in the high schools within Maseru Health Service Area (HSA). The title of the study is *"Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru HSA"*. I have enrolled for a Master of Social Science in Nursing at the University of the Free State (UFS) and this research will be conducted in fulfilment of the above-mentioned degree.

A copy of the research proposal will be send to you for review as soon as it has been approved by the Ethics Committee of the Faculty of Health Science of UFS.

Your co-operation will be highly appreciated.

Thank you.

Yours sincerely

.....

M.L. Moletsane

ADDENDUM B

Approval letter to conduct the study from the Ministry of Health

MINISTRY OF HEALTH
AND SOCIAL WELFARE
P.O. BOX 514
MASERU

LESOTHO

May 27, 2002

H\PROJ\40

TO: MRS. M.L. MOLETSANE

Dear Sir / Madam,

RE: PERMISSION TO CONDUCT RESEARCH ON UNMARIED FEMALE ADOLESCENTS' KNOWLEDGE AND ATTITUDES TOWARDS THE USE OF CONTRACEPTIVE SERVICES IN MASERU HEALTH SERVICE AREA

Please refer to your request to conduct the research on the above mentioned subject. The Ministry of Health and Social Welfare approves and permits you to go ahead however you are urged to update Family Health Division on the progress of your study.

Good Luck.

Sincerely,

DR. T. RAMATLAPENG
DIRECTOR GENERAL OF HEALTH SERVICES

ADDENDUM C

Letter requesting permission to conduct the study to the Ministry of Education

Ha Makhoathi
P.O. Box 12422
MASERU
100

17th April, 2002

The Chief Education Officer-Secondary
Ministry of Education
MASERU
100

Dear Sir

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, hereby, request permission to conduct research in the high schools within Maseru Health Service Area (HSA). The research is on *"Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru HSA".* I have enrolled for a Master of Social Science in Nursing at the University of the Free State (UFS) and this research will be conducted in fulfilment of the above-mentioned degree.

Please find an attached list of secondary and high schools in the area. Your co-operation will be highly appreciated.

Thank you.

Yours sincerely

.....

M.L. Moletsane

ADDENDUM D

Approval letter to conduct the study from the Ministry of Education

LESOTHO

Ministry of Education

26 July 2002

REFERENCE: ED/N/7/5

Mrs. M. L. Moletsane
Ha Makhoathi
P. O. Box 12422
MASERU 100

Dear Madam

YOUR REQUEST TO CONDUCT RESEARCH IN SECONDARY AND HIGH SCHOOLS

We would like to acknowledge receipt of your letter dated 17 April 2002, in connection with the above subject.

Your topic **"Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru Health Service Area"** has led to engaging in a lot of consultations, and hence a delay in responding. It is understandable that majority of the population cited above is the secondary and high schools. However, there are different perceptions on the approach of sensitive issues like what is indicated in your topic.

You are granted permission to conduct the research. On the other hand, the Ministry of Education wishes to protect those would like to participate as well as those who would not like to participate. Therefore, as a researcher, you should take this into consideration.

Yours sincerely

L. B. MAHLOKA
For Principal Secretary - Education

MINISTRY OF EDUCATION
SECONDARY EDUCATION
2002 -07- 26
BOX 47 — TEL: 322892
LESOTHO

P.O. Box 47, MASERU 100 Tel: 313628 Fax: 310206 Telegram: EDUCATION

ADDENDUM E

Letter requesting permission to enter the field to the principals of the schools

Ha Makhoathi
P.O. Box 12422
MASERU
100

29th August, 2002

The Principal
.....
.....
.....
.....

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I kindly request permission to conduct research in your school. The research is on *"Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru Health Service Area"*, and the target population for the study is females between 13 and 21 years. All high schools in the area will be included in the research.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences at the University of the Free State (UFS), the Ministry of Health and Social Welfare and the Ministry of Education.

I am currently pursuing my Masters degree in Nursing Science at UFS and this research will be conducted in fulfilment of the above-mentioned degree.

Your co-operation will be highly appreciated.

Thank you.

Yours sincerely

.....
M.L. Moletšane

ADDENDUM F

Parental consent

Consent form for the parent

STUDY TITLE: **Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru Health Service Area**

RESEARCHER: **'Matšepo Lydia Moletsane**
(09266) 8771914

You are kindly requested to allow your daughter to participate in a research study which is done to find out what the adolescent girls know about contraceptive services/family planning and how do they feel about the use of such services. She will be asked to complete a questionnaire which will take approximately 30 minutes.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Free State, the Ministry of Health and Social Welfare, the Ministry of Education and the Principal of the School where your daughter is a student.

There are no risks involved in completing the questionnaire. There may be no direct benefits to the participants of this study, but there may be improvements in the adolescent health programs following completion of this study which can be used to prevent unwanted teenage pregnancies.

Your daughter's participation in this study is voluntary, she has the right to withdraw at any time without penalty and her school activities will not be affected. She will not get any compensation for her participation.

Her name will not appear in the questionnaire. Study data will be coded so the data will not be linked to her. All study data will be collected by the researcher and stored in a safe place, no one will have access to the raw data. The final report containing anonymous quotations will be available to all at the end of the study. You are free to ask me questions about the research or your daughter's participation.

I have read this consent form and voluntarily allow my daughter ..... to participate in this study.

....
PARENT'S/GUARDIAN'S SIGNATURE **DATE**

I have explained this study to the above parent/guardian and have sought her understanding for informed consent.

....
RESEARCHER'S SIGNATURE **DATE**

ADDENDUM G

Individual respondents consent

Informed consent form for the questionnaire

STUDY TITLE: **Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru Health Service Area**

RESEARCHER: **'Matšepo Lydia Moletsane**
(09266) 8771914

You are invited to participate in a research study which is done to find out what you know about contraceptive services/family planning and how do you feel about the use of such services. You will be requested to complete a questionnaire which will take approximately 30 minutes.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Free State. There are no risks involved in completing the questionnaire. There may be no direct benefits to the participants of this study, but there may be improvements in the adolescent health programs following completion of this study which can be used to prevent unwanted teenage pregnancies.

Your participation in this study is voluntary, and you have the right to withdraw at any time without penalty and your school activities will not be affected. You will not get any compensation for your participation.

Your name will not appear in the questionnaire. Study data will be coded so the data will not be linked to you. All study data will be collected by the researcher and stored in a safe place, no one will have access to the raw data. The final report containing anonymous quotations will be available to all at the end of the study.

I have read this consent form and voluntarily consent to participate in this study.

....
PARTICIPANT'S SIGNATURE **DATE**

I have explained this study to the above participant and have sought her understanding for informed consent.

....
RESEARCHER'S SIGNATURE **DATE**

ADDENDUM H

Focus group consent

Consent form for the focus groups

STUDY TITLE: **Unmarried female adolescents' knowledge and attitudes towards the use of contraceptive services in Maseru Health Service Area**

RESEARCHER: **'Matšepo Lydia Moletsane**
(09266) 8771914

You are invited to participate in a research study which is done to find out what you know about contraceptive services/family planning and how do you feel about the use of such services. The study has been approved by the Ethics Committee of the Faculty of Health Sciences at the University of the Free State

A group interview will be conducted which will last approximately one hour. The interview will be tape-recorded with your permission. During the interview questions will be asked and you will be requested to interact as a group and discuss issues as they arise. The tape will be transcribed and destroyed afterwards.

The interview will be conducted by a facilitator and the researcher will be present as an observer taking notes. The information discussed during the interview will be treated confidential so it will not be disclosed publicly. The final report containing anonymous quotation will be available to all.

There are no risks involved in the study. There may be no direct benefits to the participants, but there may be improvements in the adolescent health programs following completion of this study which can be used to prevent unwanted teenage pregnancies.

Your participation in this study is voluntary, and you have the right to withdraw at any time without penalty and your school activities will not be affected. You will not get any compensation for your participation.

I have read this consent form and voluntarily consent to participate in this study. I also affirm that I will not communicate or in any manner disclose publicly information discussed during the course of this focus group interview. I agree not to talk about material relating to this study or interview with anyone outside my fellow focus group members and the researcher or facilitator.

....
PARTICIPANT'S SIGNATURE **DATE**

I have explained this study to the above participant and have sought her understanding for informed consent.

....
RESEARCHER'S SIGNATURE **DATE**

ADDENDUM I

Approval letter to conduct the study from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State

GESONDHEID
HEALTH

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE

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Fakulteit Gesondheidswetenskappe
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E-mail address: gndkgcn@med.uovs.ac.za

Mrs G Niemand

24th May 2002

MS ML MOLETSANE
SCHOOL OF NURSING
UNIVERSITY OF THE FREE STATE

Dear Me Moletsane

ETOVS NR 91/02
RESEARCHER: MS ML MOLETSANE
PROJECT TITLE: UNMARRIED FEMALE ADOLESCENTS' KNOWLEDGE AND ATTITUDES TOWARDS THE USE OF CONTRACEPTIVE SERVICES IN MASERU HEALTH SERVICE AREA.

You are hereby informed that the Ethics Committee approved the abovementioned project during their meeting held on the 21st May 2002.

Your attention is kindly drawn to the following:

a) A progress report be presented not later than one year after approval of the project
b) That all extentions, amendments, serious adverse events, termination of a study etc have to be reported to the Ethics Committee

Will you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries

Yours faithfully

For DIRECTOR: MEDICINE ADMINISTRATION

ADDENDUM J

Focus group transcriptions

FOCUS GROUP TRANSCRIPTIONS (Plus the researcher's notes) (Junior group 13-16 years)

INTRODUCTION

I would like to thank all of you for coming today. My name is (name of the researcher) and I am conducting a research project on adolescents' knowledge and attitudes towards the use of contraceptive services. The purpose of these discussions is for you to share your opinions and feelings about these issues so that appropriate health services which are sensitive to your needs can be rendered. Mrs (name of the facilitator) will be facilitating the discussion and I will be an observer taking notes. With your permission, the discussion will be recorded on audiotape.

Now that we know the purpose of these discussions, I (the facilitator) would like to state the ground rules that we should bear in mind during the discussion. There are no right or wrong answers to the questions I will ask, so please feel free to say whatever you really feel. All your views are important, so let everyone have a turn to say something. I will ask you a question and other questions will arise as we continue the discussion. Feel free to bring up other issues that you feel are relevant.

F (Facilitator)	➢ ***"Why do you think female adolescents do not use contraceptives?"*** ➢ ***"Yes?"***
UG (Urban girl)	*"Well, it is obvious that girls do not use contraceptives, because when you visit the clinic for your own health problems you find that girls of our age are there attending the antenatal clinic, because they are pregnant."*
F	***"And what do you think are the reasons?"*** **(Clarified the question, because the first speaker did not answer it.)**
RG (Rural girl)	*"It is because parents do not discuss these things* **(contraceptives)** *with their children, they feel uncomfortable."*
F	***"Mm, okay."***
UG	*Adding to what she has said, it is because of the parents. They are afraid to tell their children that this is the way, they withhold information."*
UG	*"Sometimes when you go to the clinics, you find that the nurses are not friendly."*
RG	*"It is because some girls are not aware of these contraceptives. No one is advising them on what to do and not to do."*

F ***"Thank you. Who else wants to say something?"***

UG *"Mm ... Another reason is that nowadays girls engage in sex at a very early age before they know the things that can help them to prevent pregnancy. And you find that girls do not tell their parents when they start menstruating, therefore the parents will not be able to advise them accordingly. So they* **(young girls)** *indulge in sex without knowing what is really happening."*

F ***"Oh. Yes lady!"***

RG *I think they are afraid of their parents, they don't want them to know that they are sexually active."*

F ***"Mm."***

UG *I think a girl can have a relationship with a boy who does not approve the use of contraceptives. Because of your love for this boy you agree not to use contraceptives. Why? Because you buy his love, you think that he will leave you if you use them."*

F ***"Okay."***

RG *"Many girls often say that contraceptives cause weight loss, and when you are skinny, boys won't even look at you."*

F ***"Okay."***

UG	*"Some girls do not take their parents' advices. They want to experiment and see what will happen."*
F	***"Mm."***
RG	*"I think it is because our boyfriends do not want to use condoms."*
F	***"Do they give reasons?"***
RG	*"No, they don't give reasons."*
UG	*"The boys say that they don't get sexual satisfaction when they use condoms, this is why girls do not use them,* **(condoms)** *they want to satisfy their boyfriends."*
F	***"Mmh. But do you think family planning services are available for adolescents?"***
RG	*"Yes, they are available."*
F	***"Do you all agree that they are available?"***
G (Group)	*"Yes."***(All responded.)**
F	***"Are you welcomed at the clinics?"***
RG	*"If you are at our age and you go to the clinic, the nurses will ask you; 'what are you doing with contraceptives at your age'? But she will give you just because they are supposed to be issued to the clients."*

F	***"Mm. Do you have other opinions?"***
UG	*"Hm ... in addition to what she has said, in fact at this age we don't feel comfortable to go to the clinics, because we already know that we will be asked embarrassing questions, especially because we are still young."*
F	***"Mm. Are there any contraceptive methods that you know?"***
G	*"Yes."*
F	***"Can you mention them?"***
UG	*"Condom, injection and pill."*
F	***"And the pill?"***
RG	*"And the loop."*
F	***"And?"***
RG	*"Loop."*
F	***"And the loop, okay. How do you feel about the use of contraceptives? You are all expected to participate in the discussion."***

RG *"They are very important especially now that there are diseases like AIDS, condoms prevent transmission of AIDS."*

F ***"Mm."***

UG *"They are important, because they prevent unwanted pregnancy. If a person is not using contraceptives, she will have babies one after the other, which makes it difficult to support them especially here in Lesotho, because there are no jobs."*

F ***"This lady had her hand up, you will have your turn after her"* (Controlling turns.)**

UG *"They reduce the rate of abortion where you find that the girl is pregnant and wants to get rid of the pregnancy."*

F ***"Mm, how do you feel? Do you want to say something?* (Looking at one of the group members who was moving towards the edge of the chair as if she wanted to stand up.)**

RG *"Yes, the population is increasing rapidly and in the end people will have nowhere to stay, so they really help."*

F ***"Okay."***
(Silence.)

F ***"Do you think you have exhausted this contraceptives issue, or do you still have something to say?*** **(Looking around.)**

UG *"Well, I think it is just a word of advice to the nurses. Please!* **(Stressed.)** *When we go to the clinics for contraceptive services, they should not ask embarrassing questions which will make us regret going there."*

F ***"Thank you."***

RG *"And again nurses should try by all means to educate girls on how to use contraceptives, because you will find that someone has them, but she doesn't know how to use them."*

F ***"Mm."***

UG *"There are some people who are staying far from the clinics, especially in the rural areas, so nurses should take the services to them."*

F ***"Mm."***

UG *"I have a request, that contraceptives should be free. We are very poor here in Lesotho; we are already struggling to get food."*

F	***"Do you have other advice?*** **(Looking around.)** ***Well, I believe that you ..."*** **(Interrupted by a member who wanted to say something.)**
RG	*I was saying that nurses should consider the age when girls go to the clinics for contraceptives, they should not be given to people of our age."*
F	***"Mm. What do you think is the appropriate age to start using contraceptives?"***
RG	*"Maybe from 18 years upwards."*
UG	*"I beg to differ. Sex and pregnancy that are happening now happen to people of our age. Not only to people who are 18 years and older. As long as the girl is menstruating, she should be given contraceptives. If we are prevented from using them, we will find ourselves in danger and having babies."* **(Laughter.)**
F	***"Mm. Yes."***
RG	*One other thing, adolescents are sometimes raped, and if they are on contraceptives unwanted pregnancy can be prevented, because even if you have a condom there is no time to negotiate."*
F	***"Mm. Thank you."***

UG *"Contraceptives are very important to the adolescents, because they die more than adults because of AIDS, so use of contraceptives, especially condom, can prevent it."*

F ***"Okay."***

UG *"I have a recommendation to the nurses, they must talk to the parents, because they are misleading us. I have heard one parent saying that condoms have AIDS, claiming that they produce worms when put in hot water. I really don't think this is true, but things like this prevent some girls from using condoms and they become pregnant."*

F ***"Are you recommending that parents must be given health education?"***

UG *"Yes."*

F ***"Mm."***

RG *"Workshops should be organized at the clinics."*

F ***"Mm. Workshops should be organized at the clinics.*** **(Paraphrased.)** ***You have been quiet for some time, would you like to say something?"*** **(Looking at one of the group members who was not participating actively.)**

RG *"I think women who have children must be educated about the pros and cons of many children so that they can be able to make their own decisions about the use of contraceptives."* **(Lost focus of the discussion.)**

UG *"Nurses should advise the parents to let their daughters use contraceptives, because they will still use them secretly even if the parents are afraid to talk about them."*

F ***"Okay."***

UG *"Parents withhold this information from their girls, because they think that if they can talk to them about contraceptives, the girls will be out of control. And if the girls can be pregnant out if ignorance, it is as if she did not take advice."*

UG *"To add to that, I'm appealing to the parents not to withhold information from their daughters, because if they do the girls can end up pregnant. Parents will start blaming themselves, but it will be too late."*

F ***"We are about to end our discussion. I want you to say anything you want in relation to our topic."***

UG *"I wish the Ministry of Health can talk to men who are abusing their wives when they use contraceptives."* **(Not the subject of interest.)**

RG *"Especially, because these men are the ones who do not want contraceptives, they say that they have AIDS."* **(Discussion losing direction.)**

F ***"Okay, let's concentrate on unmarried adolescents."*** **(Redirecting the discussion.)**

RG *"Workshops should be organized for the adolescents at the clinics where they will be educated about the health issues. Their health is in their hands, but they will take responsibility when they know what to do."*

F ***"Mm."***

UG *"I agree that adolescents should be made aware of these things so that they can be able to make informed decisions."*

F ***"Mm, then individuals can decide which way to go."***

RG *"I want to advise girls. They should not let their boyfriends mislead them, sex is not a sign of love."*

F ***"Mm. Thank you."***

RG *"If you can observe what is happening now, adolescents are the ones who are suffering from sexually transmitted infections (STD) and AIDS, because they don't want to take advice from their parents; they think they know better, because they are taught these things at schools."*

UG *"In addition I can say that girls like ourselves should not feel ashamed to tell our boyfriends to use condoms. This is important to both boys and girls."*

F ***"Thank you. Do you think you have said it all?"***

UG *"I would like to advise the girls not to take advice from their friends, because sometimes a friend can mislead you intentionally, and tell you not to use contraceptives when she is using them herself. They must trust their parents and the nurses."*

F ***"Thank you. Yes."***

UG *"I want to talk to the girls, don't be afraid to tell your boyfriend to use contraceptives when you have sex. If he doesn't want to, you better leave him instead of putting yourselves in trouble, because of pregnancy, especially YOU girl."* **(Tone of voice raised on the last sentence, stressing the "YOU".)**

RG ➲ *"Girls drop out of school, because of their boyfriends pretending to love them and getting them pregnant."*

- *"Sometimes girls may have contraceptives if they don't know how to use them or they have expired, she will still end up pregnant."*

UG *"Adolescents must be aware of the expiry dates of the contraceptives, including condoms. You may think that you are protected only to find that you are not, because they have expired, and you can still get pregnant."*

F ***"Yes lady?"***

UG *"Girls must be careful, because sometimes your boyfriend can make you believe that he is using a condom and puncture it at the tip while you are still taken up in the act. This can also result in pregnancy."*

RG *"More often boys are misleading girls. He will tell you that God did not say anything about contraceptives. Now I want to advise girls, we must use contraceptives, because we are sexually active even though we are not married. It is true God did not say anything about them, because he knew that sex was for married people only."*

UG *"Girls should not be promiscuous when they are using contraceptives and think that they can have 50 boyfriends, because they will not get pregnant.* **(Laughter.)** *They should really be careful of their behaviour."*

F ***"Their behaviour?"***

UG *"Yes."*

RG *"Nurses should also check the expiry dates before they issue contraceptives."*

F ***"Do you want to say something?*** **(Participant shook her head.)** ***Okay, sorry."***

UG *"Adolescents have a tendency of saying; 'it was so spontaneous, I don't know what happened'. If you are not on a pill or an injection, it is always best to have a condom in your pocket."*

F ***"Mm."***

RG *"Girls should use contraceptives with caution, especially the injection and the pill. I have heard that a person who has used contraceptives while she is still young will not be able to bear children when she is married and wants them."*

F ***"She will not be able to bear children. What do you think about that?"***

RG *"I am really afraid to use them* **(contraceptives)**, *because it is not a nice thing when a person is grown up and married, but cannot have children."*

F ***"Mm."***

UG *"I am not sure, but I think we should be taught about contraceptives so that we can be able to do the right thing."*

F

- ***"Is there any other information that you would like to share with us in relation to what we have discussed?"***
- **(Silence.)**
- ***"Are you satisfied?"***

G *"Yes, we are satisfied."*

F ***"Thank you very much for your time and for sharing your views with us."***

FOCUS GROUP TRANSCRIPTIONS (Plus the researcher's notes) (Senior group 17-21 years)

INTRODUCTION

I would like to thank all of you for coming today. My name is (name of the researcher) and I am conducting a research project on adolescents' knowledge and attitudes towards the use of contraceptive services. The purpose of these discussions is for you to share your opinions and feelings about these issues so that appropriate reproductive health services which are sensitive to your needs can be rendered. Mrs (name of the facilitator) will be facilitating the discussion and I will be an observer taking notes. With your permission, the discussion will be recorded on audiotape.

Now that we know the purpose of these discussions, I (the facilitator) would like to state the ground rules that we should bear in mind during the discussion. There are no right or wrong answers to the questions I will ask, so please feel free to say whatever you really feel. All your views are important, so let everyone have a turn to say something. I will ask you a question and other questions will arise as we continue the discussion. Feel free to bring up other issues that you feel are relevant.

F (Facilitator)	***"Why do you think adolescents do not use contraceptives?"***
UG (Urban girl)	*"Mmh, the way I have heard it, boys do not want to use condoms, because they believe that condoms destroy their girlfriends' legs."*
F	***"What do you girls say about that?"***
UG	*"Well, I am not sure."*
RG (Rural girl)	*"That is not true, the truth is that boys say that they don't get sexual pleasure when they are using condoms."*
F	***"Mm."***
RG	*"I think that mm... I think there are other contraceptives which require us to go to the clinics, like the injection, but the nurses are not friendly to the adolescents. Therefore we feel embarrassed and afraid to go there, because we already know that they are going to insult us before they serve us."*
F	***"Thank you."***
RG	*"I think most of the girls are afraid to go to the family planning clinics, because they don't want to be seen by their elders. It will be obvious that they are preventing pregnancy because they are sexually active."*

F ***"Do you want to say something?"***

UG *"Girls are afraid to attend family planning clinics, because they know that premarital sex is not allowed."*

RG *"Some adolescents think that contraceptives are for married people only."*

F ***"What is your opinion about this?"***

UG *"Well, I think anybody can use them if she wants."*

UG *"I agree with her, anybody who is sexually active, but doesn't want to have a baby can use them."*

F ***"Mm. Other reasons?"***

RG *"Yes, I think it is because of our parents. They don't want us to use contraceptives, because they think that we will be wild and sleep around freely knowing that we will not get pregnant."*

F ***"Mm."***

UG *"To add on that, parents are afraid to take us to the family planning clinics because adolescents who are using contraceptives are promiscuous."*

RG *"I think we don't know the contraceptive methods and where to get them, because our parents are afraid to tell us about them. They don't feel free, they shout at us even when you ask questions."*

F	***"Do other members of the group know the different methods of contraceptives and where to find them?"***
UG	*"I know pills and the injection; they are available at the clinic."*
RG	*"Other methods are the loop and condoms."*
RG	*I also know these methods that they have mentioned."*
UG	*"I have heard that others are called norplants, but I have never seen them."*
F	***"Mm."***
UG	*"One other thing, your boyfriend will tell you. I don't eat a wrapped sweet* ***(ha ke je pompong e phuthetsoeng)****. You will try to refuse no; jo; no;* **(making zig zag movement with her hand).** *But, because of love you will eventually sleep with him without protection."*
F	***"I haven't heard others' views."***
RG	*"Again these boys say that condoms cause AIDS."*
F	***"What do you say?"***
UG	*"These are only the boys' tactics to scare us, condoms do not cause AIDS."*

UG *"I think young people like ourselves are afraid to use contraceptives, because they think that things like the injection will sterilize them."*

F ***"Mm."***

RG *"In fact I think if a person uses contraceptives while she is still young, she will never have children when she is married."*

F ***"Yes. Mm."***

UG *"I blame our parents and teachers, because they are supposed to teach us about these things, but they don't. Instead they shout at us when we ask questions about condoms and other sex related issues, especially our parents. It is their responsibility to explain to the children the moment they realize that the child can understand what she is told about life and health issues. If they shout at us we want to experiment these things."*

RG *"Can I please add to that parents know very well that their children are sexually active, but they want to pretend that they are not and they will only do it when they are married."*

F ***"Have you exhausted the reasons why female adolescents do not use contraceptives?"***

RG *"Well, I am satisfied."*

F	***"But I heard one person say she doesn't know where to get contraceptives. What about the rest of the group?"***
G (Group)	*"We really don't know. We don't know."* **(All talking at the same time.)**
F	***"Okay. Have you been to the nearest clinics and find out what is happening?"***
RG	*"We don't go near the clinics."*
UG	*"We are afraid."*
UG	*"We don't go near the clinics, we are afraid."*
RG	*We are afraid of being scolded."*
F	***"You are afraid of being scolded"***
RG	*I am afraid that when I leave the clinic after asking them questions they will tell my mother that your daughter was here asking about contraceptives. Or maybe talk about me and say this girl must be sexually active."*
F	***"Besides what we have already discussed, how do you feel about the use of contraceptives?"***

UG *"I really prefer to use them, because there is no use denying that we are sexually active. The more you deny it, the more you put yourself at risk of having a baby and your future will be destroyed."*

F ***"Mm."***

RG
- *"Contraceptives are not good for the unmarried adolescents. But according to their lifestyle, they live sex, they say it is the rule of their love. So they might as well use them.*
- *Adolescents have no idea about contraceptives, where to find them and how to use them. They are just like me, they know condoms only, there is nothing that I can use except a condom."*

F ***"Mm, okay."***

RG *"I think adolescents should use contraceptives, because they will keep on having sex and make babies young as they are. Their future will be destroyed, because they drop out of school when they are pregnant. Sometimes when you have a baby your parents don't take you back to school."*

RG *"I really think they* **(contraceptives)** *should be used, because it looks like adolescents are increasing the population and our country is very poor."*

F ***"Mm."***

UG *"We female adolescents are afraid of our boyfriends more than we can take care of our health. When he says we are going to have sex now, I end up sleeping with him, because I am afraid that he will leave me if I don't."*

UG
- *"It is true that we are afraid of our boyfriends. We don't want to be labelled as chickens, they call us chickens if we don't sleep with them."*
- *"Again contraceptives are very good in prevention of abortion, because we make unplanned babies. If you are afraid to tell your parents, you can end up performing an abortion you are not safe you can also die. Your health is at risk."*

F ***"Mm."***

RG
- *"I think they are necessary, because if you become pregnant you are already destroying your future."*
- *"And maybe you are already needy, your parents are struggling to pay your school fees, if you bring extra burden into the family by having a baby, it becomes difficult."*

RG *"I don't have a problem with the use of contraceptives when a person knows that she is sexually active. But we are scared by the people who are using them, they don't respect themselves like a girl is expected to, they sleep around with anybody."*

F ***"Mm."***

UG *"I think contraceptives increase our sexual feelings, because when a person has had an injection or is on a pill, she starts living a promiscuous life."*

F ***"I see. How do you know when a person is using them?"***

UG *"They talk to their friends."*

F ***"Okay."***

RG *"I have mixed feelings about the use of contraceptives:*

- *They should not be used, because those who are using them sleep around, knowing that they will not get pregnant.*
- *On the other hand, they should be used to prevent abortion; sometimes adolescents die due to abortion."*

F ***"Mm."***

RG *"The rate of rape is increasing, sometimes innocent girls are raped and have unplanned babies, so contraceptives can prevent these pregnancies."*

F ***"Okay."***

RG *"Sometimes they are afraid to report that they have been raped."*

UG *"They are very helpful, because you will not know when you will be raped and you won't have a chance to give a rapist a CD* **(condom)** *so at least injection is better."*

F ***"Mmh. We have discussed your feelings about the use of contraceptives. Now I have a challenge for you. What should be done to help the adolescents in this regard?"***

UG *"I don't know. Maybe we can be taught about these things in the presence of our parents, because they deny the truth that their children are sexually active. Education must include everybody at high school, because young girls become pregnant out of ignorance."*

F ***"Mm."***

RG *"I was going to say the same thing."*

RG *"I think it is important for the health workers to educate parents and make them aware that it is not a bad thing to talk to their children about sex."*

F ***"Mm."***

UG *"I would really like the nurses to talk to the parents alone and hear their views, then bring in the adolescents and have a joint discussion. I can be able to talk freely to my parents when the nurses are part of the discussion."*

F ***"Mm."***

UG *"I wish our parents can listen to this tape so that they can be able to understand our feelings. But I don't think it is a good idea to combine parents and adolescents, because I will not feel comfortable to discuss sex and contraceptives in front of my parents. They will think that I am out of control* ***(poho ea khothu)****."*

F ***"Mm."***

RG *"I think nurses who are providing family planning services must be friendly to the adolescents seeking family planning services and regard them as responsible individuals who want to take care of their health, not as silly girls. We should also respect ourselves when we are on contraceptives."*

RG *"I encourage nurses to educate adolescents and parents about contraceptives so that we can be able to decide what to do."*

UG *"Especially our fathers. If I can ask my father about these things, he can beat me up without any explanation. But it is their responsibility to give us the direction."*

RG *"If they* **(parents)** *were educating us about sex and its consequences we would respect ourselves. Now they don't say a word. This is why we continue having sex without proper measures to prevent pregnancy, because we don't know them."*

UG *"Apart from that, there are some parents who are educating their daughters, but they don't take advice from their parents; they listen to their boyfriends. Adolescents should start preparing for their future by listening to their parents."*

RG *"I think it would be better if nurses can organize separate meetings for the parents and adolescents, because culturally talking about sex in the presence of parents shows lack of respect."*

UG *"It's like I am no longer a girl, but a woman."*

UG *"Mm, I am now a woman."*

UG *"Yes, a woman."*

UG *"One other thing, I don't know what is wrong with girls. We are easily deceived by boys and they even call us fools. When you are with him, you think that the whole world belongs to you, only to find that he comes to you to deliberately destroy your future."*

F ***"Do you think you are satisfied?"***

RG *"I suggest that boys should be educated about contraceptives and to respect the girls' decisions."*

F ***"Mm."***

RG *"Girls should be taught to be assertive. Say no to sex if you don't want to, don't be forced to do anything against your will. You don't have to impress your boyfriend by doing something that doesn't make you happy."*

UG *"Sometimes we may think that we have our own opinions and refuse to have sex, but it won't last, because I don't want my boyfriend to doubt my love for him, I will sleep with him."*

RG *"Education about contraceptives must be extended to other districts even the most remote areas, because adolescents in some of these areas have no idea about contraceptives; some don't even know condoms. This is why teenage pregnancy is high in these areas."*

RG *"I suggest that condoms must be free, even in non-governmental clinics, because some people cannot afford to buy them."*

F ***"Mm."***

RG *"I have a question. Are there any physical problems caused by contraceptives?"* **(Participant asking the facilitator).**

F	***"Please respond to this question. What do you think?"***
UG	*"It's hm ... we ... when we read some books we learn that injection and pill affect other body parts and this can result in sterility."*
F	***"Who else have read or heard something?"***
RG	*"Is it possible to get pregnant while still using contraceptives?* **(Asking the facilitator.)**
F	***"Please answer these questions."***
UG	*"You are not safe if your due date for the injection has expired, you can get pregnant."*
UG	*"The injection and the pill cause breasts enlargement. Some people experience pregnancy like signs."*
F	***"Okay. Anything more? Are you happy?"***
G	*"Yes."*
F	***"In that case."*** **/ (Interrupted.)**
UG	*"Before we conclude, let me ask you a question. I have heard other girls talking about safe period. Is it really safe?"* **(Another question from the respondent to the facilitator.)**
RG	*"What?"*

UG *"Safe period."*

F ***"Please respond to her question if you have heard something about it."***

UG *"There is nothing like a safe period, it is just one of the tactics used by boys when they want to have sex with us."*

UG *"I don't believe in a safe period, especially because most of the time I hear it from boys. I am not sure if girls also know about it."*

RG *"I believe there is a safe period in the menstrual cycle. Three days after menstruation is referred to as a safe period, because the egg which was prepared for fertilization has been released and the other one is not yet ready. This means that you cannot get pregnant."*

F ***"Mm. Thank you."***

UG *"Is it really safe? Hey, I am afraid I don't trust it."* **(Tone of voice doubtful, all laughed.)**

F ***"Are you satisfied now?"***

G *"Yes."*

F ***"Thank you very much for your time and for sharing your different views with us."***

ADDENDUM K

Questionnaires

ADDENDUM K1

English questionnaire

INSTRUCTIONS TO THE PARTICIPANTS

1. Mark the appropriate answer with a cross [X] in the blocks provided.
2. Please be honest.
3. Where you are asked to specify or give reasons, please do so in the space provided.
4. The questionnaire is written in both English and Sesotho, you are free to choose any language that you feel comfortable with.
5. The questionnaire will take approximately 20-40 minutes to complete.

FOR OFFICIAL USE

[ ][ ][ ][ ] 1-4

SECTION A

Demographic data

1. How old are you? _____ [ ][ ] 5-6

2. Place of residence:

In town	1
Outside town	2

[ ] 7

3. Religious denomination:

Roman Catholic	1
Lesotho Evangelical Church	2
Anglican Church	3
Methodist	4
Seventh Day Adventist	5
Other (specify): _____	6

[ ] 8

4. Educational level:

_____

_____

FOR OFFICIAL USE

☐ 9

SECTION B

Knowledge about contraceptives

5. How often do you hear about contraceptives?

Never heard	1
Once a week	2
Once a month	3
Everyday	4

☐ 10

N.B.: You can mark more than one responses.

6. What methods of contraceptives are you aware of?

Pill	1
Injection	2
Condom	3
Loop	4
Foam	5
Other (specify): _____	6

☐ 11
☐ 12
☐ 13
☐ 14
☐ 15

☐☐ 16-17

N.B.: You can mark more than one response.

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7. What methods that you are aware of are available at your nearest clinic?

Pill	1	18
Injection	2	19
Condom	3	20
Loop	4	21
Foam	5	22
Other (specify): _____	6	23-24

N.B.: You can mark more than one response.

8. What is your source of information regarding contraceptives?

Parents	1	25
Peers	2	26
Teachers	3	27
Nurses	4	28
Media	5	29
Literature	6	30
Boyfriend	7	31
Other (specify): _____	8	32-33

9. Do you think that contraceptives are meant for married couples only?

Yes	1	
No	2	34

10. Can the use of contraceptives cause the following:

10.1 Promiscuity

Yes	1	
No	2	35

FOR OFFICIAL USE

10.2 Sterility

Yes	1
No	2

☐ 36

10.3 AIDS

Yes	1
No	2

☐ 37

10.4 Weight loss

Yes	1
No	2

☐ 38

10.5 Weight gain

Yes	1
No	2

☐ 39

11. Do you think contraceptives have other benefits besides pregnancy prevention?

Yes	1
No	2

☐ 40

11.1 **If YES**, specify: _____

_____

☐☐ 41-42

SECTION C

Knowledge and attitudes about contraceptive/family planning services

12. What is the service time at your nearest clinic?

Monday to Friday 7 am to 5 pm	1
Monday to Friday 7 am to 4 pm	2
Monday to Friday 8 am to 3 pm	3
I don't know	4
Other (specify): _____	5

☐ 43

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13. How often are you able to get to the clinic during the service time?

Never	1
Seldom	2
Frequently	3
Always	4

☐ 44

14. How long does it take you to walk to your nearest clinic in minutes?

_____

☐☐☐ 45-47

15. What is the longest waiting time in minutes?

_____

☐☐☐ 48-50

16. How often are the contraceptive/family planning services rendered at your nearest clinic?

Once a month	1
Once a week	2
Everyday	3
I don't know	4
Other (specify): _____	5

☐☐ 51-52

17. Have the nurses offered you counselling on contraception when you have visited the clinic for other reasons e.g. flue?

Yes	1
No	2

☐ 53

18. Have you heard of the patients' information leaking out of the clinic?

Yes	1
No	2

☐ 54

19. Have you ever gone to the clinic for contraceptive/family planning services?

Yes	1
No	2

☐ 55

If NO, go to question 23.

FOR OFFICIAL USE

20. **If YES**, did you feel free to talk to the nurses about your contraceptive needs?

Yes	1
No	2

☐ 56

20.1 Give reasons: _____

_____

_____

☐☐ 57-58
☐☐ 59-60
☐☐ 61-62

21. Do you feel comfortable to go for follow-up visit at the same clinic?

Yes	1
No	2

☐ 63

21.1 **If NO**, why? _____

_____

☐☐ 64-65

22. Have you ever failed to obtain contraceptives because of lack of money?

Yes	1
No	2

☐ 66

23. If you go to the clinic, how do you think the nurses will treat, you?

With respect	1
Will insult you	2
Other (specify):	
_____	6

☐ 67

☐☐ 68-69

FOR OFFICIAL USE

SECTION D

Sexual behaviour and attitudes towards contraceptives

24. How much control do you have if your boyfriend asks you to have sex with him?

No control	1	
Very little control	2	
Complete control	3	☐ 70

N.B.: You can mark, more than one responses.

25. Why do you think girls engage in sexual activity?

To satisfy their sexual feelings	1	☐ 71
To impress their boyfriends	2	☐ 72
Sex is a sign of love	3	☐ 73
Pressure from the boyfriends	4	☐ 74
For material/financial gain from the boyfriends	5	☐ 75
Other (specify): _____	6	☐☐ 76-77

N.B.: You can mark more than one response.

26. What do you do to prevent unwanted pregnancy?

Abstain from sex	1	☐ 78
Use contraceptives	2	☐ 79
Wait for safe period	3	☐ 80
Perform abortion	4	☐ 1
Other (specify): _____	4	☐☐ 2-3

27. What do you think is the appropriate age to start using contraceptives?

_____ ☐☐ 4-5

27.1 Give reasons: _____

_____

FOR OFFICIAL USE

☐☐ 6-7

28. Are you sexually active?

Yes	1
No	2

☐ 8

29. Do you currently use contraceptives?

Yes	1
No	2

☐ 9

If NO, go to question 31.

N.B.: You can mark more than one responses.

30. **If YES**, what influences your decision to use contraceptives?

Parents	1	☐ 10
Peers	2	☐ 11
Religion	3	☐ 12
Media	4	☐ 13
Boyfriend	5	☐ 14
Nurses	6	☐ 15
Teachers	7	☐ 16
Possibility of pregnancy resulting from rape	8	☐ 17
Other (specify): _____	9	☐☐ 18-19

N.B.: You can mark more than one responses.

FOR OFFICIAL USE

31. **If NO**, what influences your decision not to use contraceptives?

Parents	1	20
Peers	2	21
Religion	3	22
Media	4	23
Boyfriend	5	24
Nurses	6	25
Teachers	7	26
Culture	8	27
Other (specify): _____	8	28-29

32. Would you advise someone to use contraceptives?

Yes	1	
No	2	30

32.1 Motivate your answer:

_____ 31-32

_____ 33-34

_____ 35-36

33. Do you think it is necessary to use contraceptives to prevent pregnancy that may result from rape?

Yes	1	
No	2	37

N.B.: You can mark more than one responses.

FOR OFFICIAL USE

34. What do you think are the consequences of unplanned pregnancy?

Rejection by the family and friends	1	38
School drop-out	2	39
Illness and or death	3	40
Other (specify): _____	4	41-42

THANK YOU FOR YOUR TIME AND CO-OPERATION!

ADDENDUM K2

Sesotho questionnaire

LITAELO HO BA NKANG KAROLO

LIPHUPUTSONG

1. Tšoaea karabo ka sefapano [X] mabokoseng a bontšitsoeng.
2. Ke kopa u bolele 'nete.
3. Moo u kopuoeng ho bolela kapa ho fana mabaka, etsa joalo sebakeng se bontšitsoeng.
4. Lipotso tsena li ngotsoe ka sekhooa le Sesotho, u na le bolokolohi ba ho khetha puo eo u batlang ho e sebelisa.
5. Lipotso tsena li tla nka metsotso e ka bang 20-40 ho li araba.

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1-4

KAROLO EA A

Tse amanang le motho

1. Lilemo tsa hau li kae?_____ | | | 5-6

2. Sebaka sa bolulo:

Toropong	1
Kantle ho toropo	2

| | 7

3. Botho ba kereke:

Roma	1
Fora	2
Chache	3
Wesele	4
Seabata	5
Tse ling (bolela): _____	6

| | 8

4. Boemo ba thuto:

_____

_____

FOR OFFICIAL USE

☐ 9

KAROLO EA B

Tsebo ka lithibela-pelei

5. Ke hakae u utloang ho buuoa ka lithibela-pelei?

Ha ke e so utloe	1
Hang ka beke	2
Hang ka khoeli	3
Letsatsi le leng le leng	4

☐ 10

N.B.: U ka tšoaea karabo tse fetang bonngoe.

6. Ke mefuta efe ea lithibela-pelei eo u e tsebang?

Pilisi	1	☐ 11
Ente	2	☐ 12
Khohlopo/condomo	3	☐ 13
Sekhoqetsane/lupu	4	☐ 14
Lekoeba	5	☐ 15
Tse ling (bolela): _____	6	☐☐ 16-17

N.B.: U ka tšoaea karabo tse fetang bonngoe.

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7. Ke mefuta efe eo u e tsebang e fumanehang cliniking e haufi le uena?

Pilisi	1	18
Ente	2	19
Khohlopo/condomo	3	20
Sekhoqetsane/lupu	4	21
Lekoeba	5	22
Tse ling (bolela): _____	6	23-24

N.B.: U ka tšoaea karabo tse fetang bonngoe.

8. Mohloli oa hau oa litaba malebana le lithibela-pelei ke ofe?

Batsoali	1	25
Methaka	2	26
Matichere	3	27
Baoki	4	28
Liphatlalatso	5	29
Lingoliloeng	6	30
Mohlankana	7	31
Tse ling (bolela): _____	8	32-33

9. U nahana hore lithibela-pelei li etselitsoe banyalani feela?

Ee	1	
Che	2	34

10. A na tšebeliso ea lithibela-pelei e ka baka tse latelang:

10.1 Bohlola

Ee	1	
Che	2	35

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10.2 Ho hloka thari

Ee	1
Che	2

☐ 36

10.3 AIDS

Ee	1
Che	2

☐ 37

10.4 Ho theoha 'meleng

Ee	1
Che	2

☐ 38

10.5 Monono

Ee	1
Che	2

☐ 39

11. U nahana hore lithibela-pelei li na le melemo e meng ntle le ho thibela bokhachane?

Ee	1
Che	2

☐ 40

11.1 **Haeba EE**, bolela: _____

_____

☐☐ 41-42

KAROLO EA C

Tsebo le maikutlo ka litšebeletso tsa lithibela-pelei/thero ea malapa

12. Nako ea tšebetso ke efe cliniking e haufi le uena?

Mantaha ho isa Labohlano 7 am – 5 pm	1
Mantaha ho isa Labohlano 7 am – 4 pm	2
Mantaha ho isa Labohlano 8 am – 3 pm	3
Haa ke tsebe	4
Tse ling (bolela): _____	5

☐ 43

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13. Ke hakae u khonang ho fihla cliniking ka nako ea tšebetso?

Hohang	1
Ka tšohanyetso	2
Hangata	3
Kamehla	4

☐ 44

14. U nka nako e kae ho tsamaea u ea cliniking e haufi le uena ka metsotso?

_____

☐☐☐ 45-47

15. Nako e telele hahoho eo u e nkang u emetse litsebeletso ke e kae ka metsotso?

_____

☐☐☐ 48-50

16. Litsebeletso tsa lithibela-pelei/thero ea malapa li fanoa hakae cliniking e haufi le uena:

Hang ka khoeli	1
Hang ka beke	2
Letsatsi le leng le le leng	3
Ha ke tsebe	4
Tse ling (bolela): _____	5

☐☐ 51-52

17. Na baoki ba kile ba bua le uena ka lithibela-pelei ha u ile cliniking ka mabaka a mang, mohlala, sefuba?

Ee	1
Che	2

☐ 53

18. U kile oa utloa litaba tsa bakuli li tsoela kantle ho clinic?

Ee	1
Che	2

☐ 54

19. U kile ua ea clinking bakeng la tšebeletso ea lithibela-pelei/ thero ea malapa?

Ee	1
Che	2

☐ 55

KAROLO EA D

FOR OFFICIAL USE

Tsa thobalano le maikutlo ka lithibela-pelei

24. U na le taolo e kae ha mohlankana oa hau a re le etse thobalano?

Ha ke na taolo	1
Ke na le taolo e'nyane haholo	2
Ke na le taolo e feletseng	3

☐ 70

N.B.: U ka tšoaea karabo tse fetang bonngoe.

25. U nahana hore banana ba etsa thobalano hobaneng?

Ho khotsofatsa litakatso tsa bona	1
Ho khahlisa bahlankana ba bona	2
Thobalano ke pontšo ea lerato	3
Khatello e tsoang ho bahlankana ba bona	4
Bakeng sa lithuso/chelete etsoang ho bahlankana	5
Tse ling (bolela): _____	6

☐ 71
☐ 72
☐ 73
☐ 74
☐ 75
☐☐ 76-77

N.B.: U ka tšoaea karabo tse fetang bonngoe.

26. U etsa eng ho thibela bokhachane bo sa batleheng?

Qoba thobalano	1
Sebelisa lithibela-pelei	2
Emela nako e bolokehileng	3
Ho ntša mpa	4
Tse ling (bolela): _____	4

☐ 78
☐ 79
☐ 80
☐ 1
☐☐ 2-3

27. U nahana hore lilemo tse nepahetseng tsa ho qala ho sebelisa lithibela-pelei ke life?

_____

☐☐ 3-4

Haeba CHE, fetela potsong ea 23.

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20. **Haeba EE**, ú ile ua utloa u lokolohile ho bua le baoki ka lithoko tsa hau tsa lithibela-pelei?

Ee	1
Che	2

☐ 56

20.1 Fana mabaka: _____

_____

_____

☐☐ 57-58
☐☐ 59-60
☐☐ 61-62

21. U utloa u phutholohile ho khutlela litsebeletsong cliniking e tšoanang?

Ee	1
Che	2

☐ 63

21.1 **Haeba CHE**, hobaneng? _____

_____

☐☐ 64-65

22. U kile oa hloloa ho fumana lithibela-pelei ka lebaka la khaello ea chelete?

Ee	1
Che	2

☐ 66

23. Ha eba u ea cliniking, u nahana hore baoki ba ka u tšoara joang?

Ka hlompho	1
Ba tla u rohaka	2
Tse ling (bolela): _____	3

☐ 67

☐☐ 68-69

27.1 Fana mabaka: _____

_____

FOR OFFICIAL USE

☐☐ 5-7

28. Na u etsa thobalano?

Ee	1
Che	2

☐ 8

29. Na u sebelisa lithibela-pelei hajoale?

Ee	1
Che	2

☐ 9

Haeka CHE, fetela potsong ea 31.

N.B.: U ka tšoaea karabo tse fetang bonngoe.

30. **Haeba EE**, ke eng e susumetsang qeto ea hau ea ho sebelisa lithibela-pelei:

Batsoali	1	☐ 10
Methaka	2	☐ 11
Tumelo ea kereke	3	☐ 12
Liphatlalatso	4	☐ 13
Mohlankana	5	☐ 14
Baoki	6	☐ 15
Matichere	7	☐ 16
Khonahalo ea bokhachane bo ka bakoang ke peto	8	☐ 17
Tse ling (bolela): _____	9	☐☐ 18-19

N.B.: U ka tšoaea karabo tse fetang bonngoe.

FOR OFFICIAL USE

31. **Haeba CHE**, ke eng e susumetsang qeto ea hau ea ho se sebelisi lithibela-pelei?

Batsoali	1	20
Methaka	2	21
Tumelo ea kereke	3	22
Liphatlalatso	4	23
Mohlankana	5	24
Baoki	6	25
Matichere	7	26
Bosechaba	8	27
Tse ling (bolela): _____	8	28-29

32. U ka eletsa motho e mong ho sebelisa lithibela-pelei?

Ee	1	
Che	2	30

32.1 Tšehetsa karabo ea hau:

_____ 31-32

_____ 33-34

_____ 35-36

33. U nahana hore ho oa hlokahala ho sebelisa lithibela-pelei ho thibela bokhachane bo ka bakoang ke peto?

Ee	1	
Che	2	37

34. U nahana hore litla-morao tsa bokhachane bo sa reroang ke life?

Ho hanoa ke lelapa le metsoalle	1	38
Ho tsoa sekolong kalehare	2	39
Kokuli le/kappa lefu	3	40
Tse ling (bolela): _____	4	41-42

KE LEBOHA NAKO EA HAU LE TŠEBELISANO 'MOHO!