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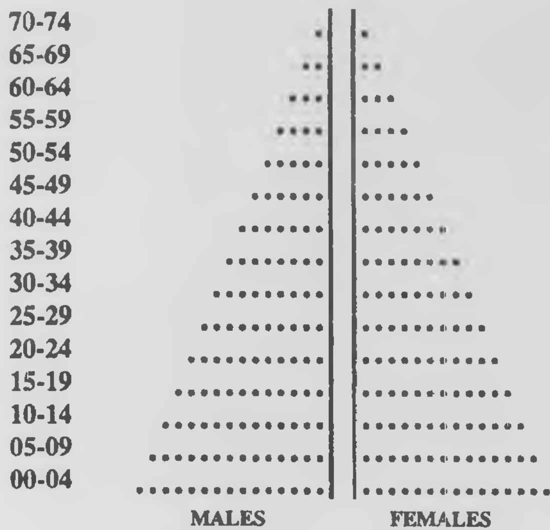

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PATTERNS OF SEXUAL BEHAVIOUR AMONG YOUNG BASOTHO WOMEN

by
Akim J. Mturi; 'Maletela Tuoane and Ian D. Diamond

Working Paper No. 25
January
1997

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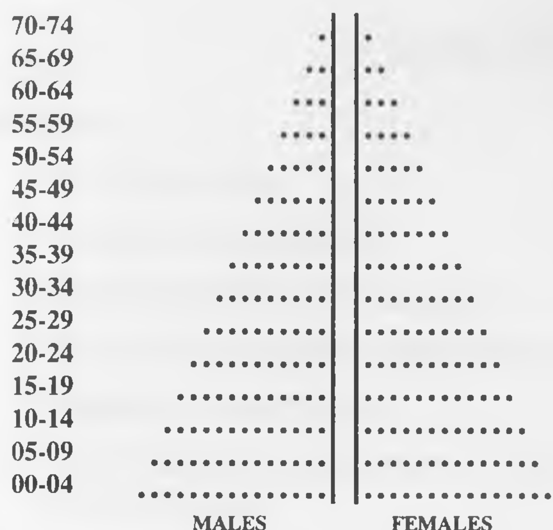

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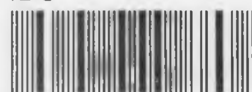
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ABSTRACT

This paper uses the 1995 Lesotho Safe Motherhood Initiative - Women's Health Survey data to study the patterns of sexual behaviour among young (12-24 year olds) Basotho women. The results show that knowledge of HIV/AIDS is high among these women but knowledge of condom is relatively low. Furthermore, a small proportion of sexually experienced young women reported to have used contraception before the survey. Marriage is the most single factor causing women to initiate sex in Lesotho. The unmarried ones, therefore, start sexual activities later in life. As expected, region of residence, type of place of residence and drinking alcohol were found to be related to the age at first intercourse for unmarried young Basotho women. Contrary to common belief, highly educated unmarried young women were found to be less likely to initiate sexual activities than those with low education.

1. Introduction

In recent years there has been a growth in premarital sexual activity. A number of explanations has been given for these trends. One such factor is later age at marriage (van de Walle, 1993) combined with their earlier physical maturity (Adadevoh et al., 1989; Gyepi-Garbrah, 1985) which has led to a lengthening of the period between menarche and marriage. Another factor is the break of traditional socialization which has been replaced by formal education which in most cases lacks family life education. Hence young people may lack guidance on sexual behaviour. Other factors include children being left without adequate parental role models due to parental conflict (Kiragu and Zabin, 1993), diminishing of the social stigma associated with pregnancy before wedlock and many social gatherings which provide the opportunity to form relationships which may develop into sexual ones due to curiosity and experimentation.

The first experience of sexual intercourse may occur at any time during adolescence, or much later, and a number of hazards surround this event for the adolescent. It may have undesirable consequences such as pregnancies (unplanned and unwanted) and sexually transmitted diseases including AIDS. These problems may be minimized by using family planning methods, but these are hardly used by adolescents in Africa. Early childbearing is also known to be associated with increased health risks to the mother and the child (see Mturi and Curtis, 1996). Socio-economically, pregnancy may force the mother to drop out of school prematurely and this may cause postponement or even curtailment of educational opportunities and the chance to acquire useful and marketable skills. Furthermore, whenever an unmarried girl becomes pregnant it includes a greater burden to the parents since young women (in sub-Saharan Africa at least) are usually dependents and this may result in parental rejection or a forced and perhaps premature marriage. However, as a way to avoid these consequences, some girls may resort to illegal abortion thereby placing their lives in jeopardy.[1] Psychological problems such as depression are

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[1] Induced abortion is illegal in many African countries unless performed to save mother's life

also likely to arise because many young people may not be ready for the responsibilities and consequences of sexual relationships.

It has been documented that the problem of sexual activity among young women is particularly high and increasing in most sub-Saharan African countries (Meekers, 1994). Due to the potential adverse consequences linked to sexuality among this segment of population, it is necessary to understand sexual behaviour among them in this region so as to guide social policies. This study involves a cross-sectional analysis of the factors associated with sexuality among young people in Lesotho. We examine patterns of sexual behaviour among Basotho women aged between 12 and 24 years old who took part in the 1995 Safe Motherhood Initiative Survey (SMIS). The lowest age at which sexual activity starts in Lesotho is twelve. The upper bound of age to study young people is debatable (see for example Bledsoe and Cohen, 1993) as there is usually a confusion between the definition of "young adults" and "girls". A 16 year old married woman with one child may appear an adult whereas a 22 year old woman in a training college may appear a girl. Therefore we cover all ages up to 24 so that we cover the full range of the initiation of sexual activity.

2. Literature Review

The existing literature indicates that sexual behaviour among young men and women and its consequences have become a major focus of attention in many sub-Saharan African countries in recent years. This is due to the rapid change in the social context of adolescent sexuality and childbearing in the region (Bledsoe and Cohen, 1993). Despite these changes, it is still taboo in many African countries to discuss sexual matters between parents and children. Unfortunately, social policies addressing this problem are also very scarce among African governments.

Various studies have also examined the factors related to age at first intercourse among young women. Whilst age and puberty status are the most mentioned biological factors related to early initiation of sex in sub-Saharan Africa, the most documented socio-economic factors are education and type of place of residence (Bledsoe and Cohen, 1993; Kiragu and Zabin, 1995; Meekers, 1994). The older a woman becomes, the longer the exposure to the risk of having sex, and hence the more likely the woman will be sexually experienced. Young women residing in urban areas and those educated are more likely to initiate sexual activities earlier than others. Urban

settings usually provide a conducive environment for sexual experimentation and offers the potential for disruption of traditional family patterns (Darabi et al., 1979). In the case of education, more years of schooling delays marriage and hence prolongs the period of exposure to sex before marriage which in turn can result to premarital sex. However, it may be argued that higher levels of educational attainment and clear educational goals are related to lower rates of premarital sex because the achieving student is likely to place high value on achievement and thus less interested in sexual relationships and, conversely, sexual relationships may distract students from their studies (Moore and Rosenthal, 1993).

Risk-taking behaviour is among the factors found to be strongly correlated with premarital sex for women in Kenya (Kiragu and Zabin, 1993). The argument is that young people who engage in behaviour such as drinking and smoking are more likely to experiment with sex (due to what is referred to as syndrome of similar risk behaviours) compared with their counterparts who do not practice these behaviours. It has been argued also that knowledge of the sources of contraception and access to radio, videos and magazines can influence early initiation of sex (Bledsoe and Cohen, 1993). As far as religion is concerned, Christians are more likely to have premarital sex than Muslim women (Meekers, 1994), possibly because chastity is still very important among Moslems.

A substantial proportion of sexually active young people in sub-Saharan Africa do not use contraception despite the fact that knowledge of family planning methods in some societies is high among them. A study of contraceptive use among high school students in Kenya, for example, showed that fewer than half of all sexually active respondents had ever used contraception (Kiragu and Zabin, 1995). Many African family planning programmes only target married couples so that unmarried young ones wishing to use contraception may find it difficult to obtain supplies. Although the situation is changing, it is still awkward for an unmarried schoolgirl, for instance, to visit a family planning clinic. It is therefore convenient for those few who want to use contraception to opt for methods which do not require them to go to clinics, such as calendar and withdrawal methods (Mturi, 1996).

3. Data: Source and Quality

This study uses data from the Lesotho Safe Motherhood Initiative - Women's Health Survey (SMI-WHS) carried out by the Ministry of Health and Social Welfare in collaboration with the World Health Organization (WHO). The SMIS-WHS interviewed a nationally representative sample of Basotho women between January and March 1995. The first draft report gives more details of the survey methodology and the sample (Ministry of Health and Social Welfare, 1995). The SMIS-WHS interviewed successfully 4,388 women aged 12 years and above. For the purpose of this study, as stated earlier, we deal with women aged between 12 and 24 years. The sub-sample which qualifies using the criteria of age comprises 1,926 young women (43.9 percent of the overall sample).

According to the distribution of the total female population in Lesotho, 20 percent reside in urban areas and 80 percent in the rural areas. But this is not the case for the SMIS-WHS data as the number of cases for rural and urban women is almost equal. Therefore, in order to validate the representativeness of the sample to the whole female population, the urban and rural samples should be weighted for their actual proportions in Lesotho (Ministry of Health and Social Welfare, 1995). The same weighting procedure is followed for the sub-sample used in this analysis. That is, the rural sample is multiplied by 0.8 and the urban sample by 0.2.

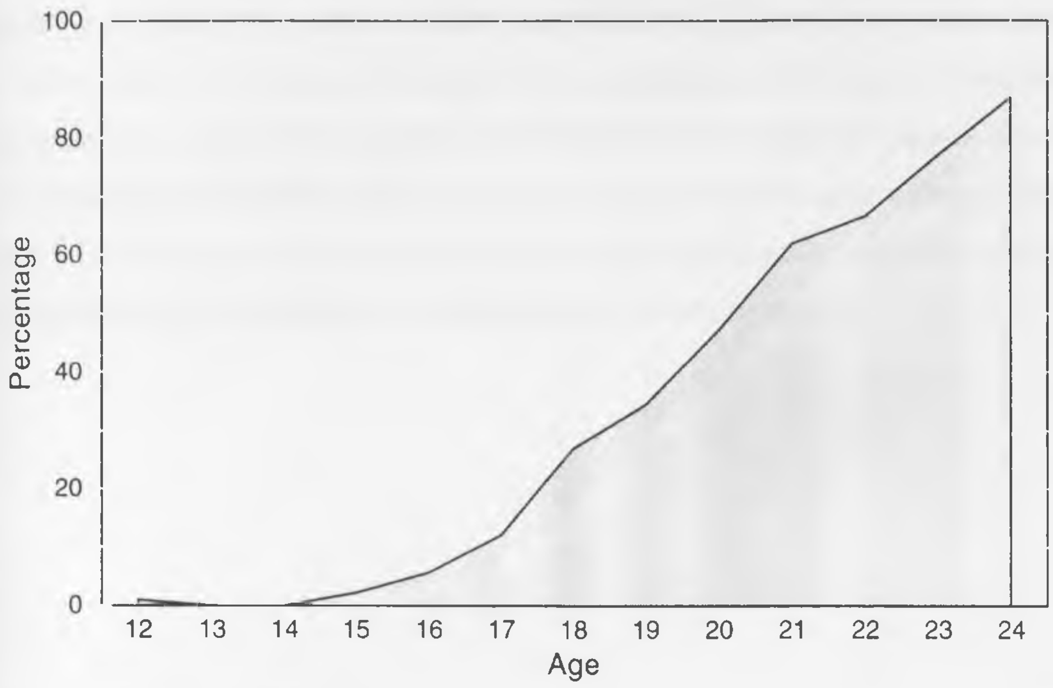
It is important to assess the quality of data on sexual behaviour especially if the information is collected from the questions on a structured questionnaire. This is because sex is a private activity, and hence sometimes people can give inaccurate information or no information at all to avoid embarrassment. The quality of data on sexual intercourse was assessed by examining internal consistency and completeness (Blanc and Rutenberg, 1991). The first exercise was to evaluate the completeness of reporting age at first sexual intercourse by examining the non-response rate. 4.6 percent of the 734 young women who had ever had sex failed to give their age at first experience. Then the age at first sexual intercourse was compared with the reported age at first marriage (for ever-married young women). Of the 498 young women who gave a valid answer to both questions, 3.8 percent gave inconsistent responses. Therefore, based on these checks, it can be concluded that there is an indication that the SMIS-WHS data on sexual behaviour is trustworthy.

The women who did not give responses to age at first intercourse and those who gave inconsistent responses between age at first intercourse and age at first marriage were excluded from the analysis as their responses are of dubious quality. The number of cases for the final weighted sub-sample is 1,815.

4. Selected Characteristics of the sampled Women

Out of the sub-sample of 1,815 young women, 26.9 percent stated that they were ever-married. As expected, the proportion of women ever-married increases with age (see Figure 1), almost 50 percent are married by age 20 and by age 24 almost 90 percent have ever married. However, it has been noted that by sub-Saharan African countries standard, Basotho women have a high age at first marriage with a mean of 18.6 years (Ministry of Health and Social Welfare, 1995).

Figure 1. Proportion of ever-married adolescent women by age.

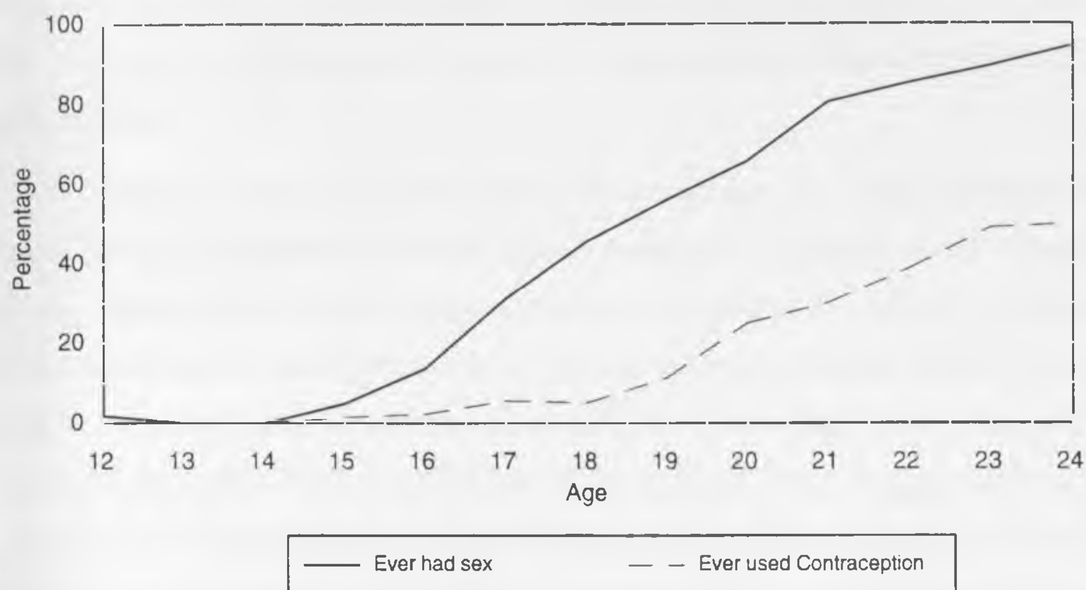


Source: 1995 Lesotho SMIS-WHS

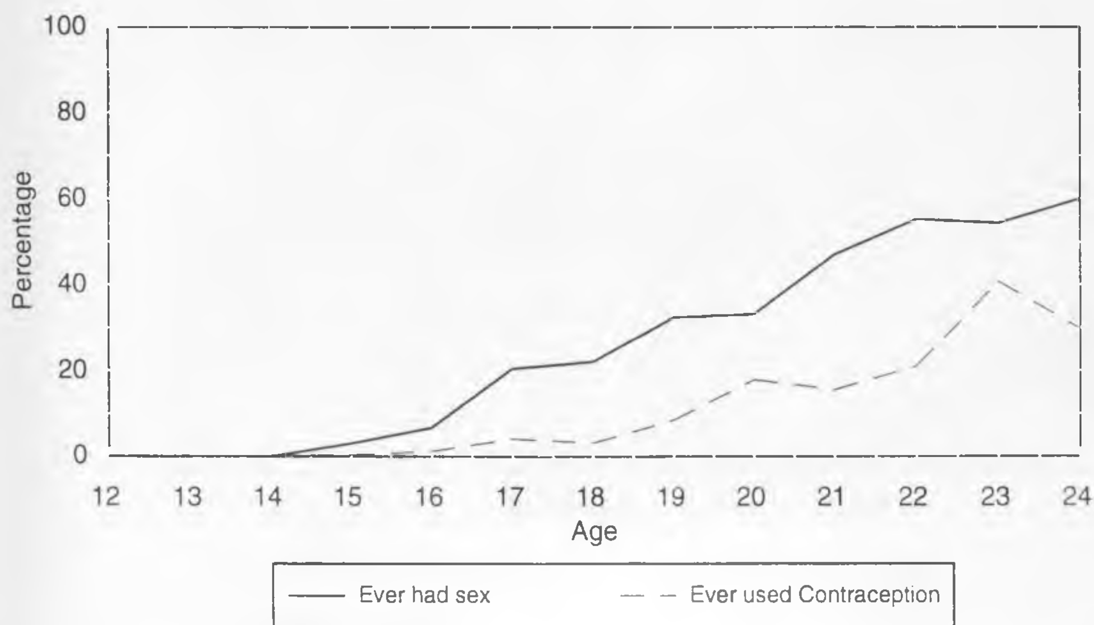
Among the problems of sexuality among young people highlighted earlier are risks to unplanned and unwanted pregnancies and sexually transmitted diseases including AIDS. As such, it is imperative to measure the extent at which young women in Lesotho are exposed to these risks. This will be achieved by looking at the proportion ever having sex, ever using contraception , ever been pregnant, ever given birth, ever heard of HIV/AIDS and ever heard of condoms. Since sexual behaviour among never-married and ever-married women is expected to be different, subsequent Figures (2,3 & 4) present separate results for all and never-married young women so as to give the general picture of the whole sample and highlight that of never married ones.

Figure 2. Proportion of Adolescent Women who Ever had Sex and Ever Used Contraception by their Current Age.

(a) <u>All Adolescents:</u>



(b) <u>Never-married Adolescents</u>



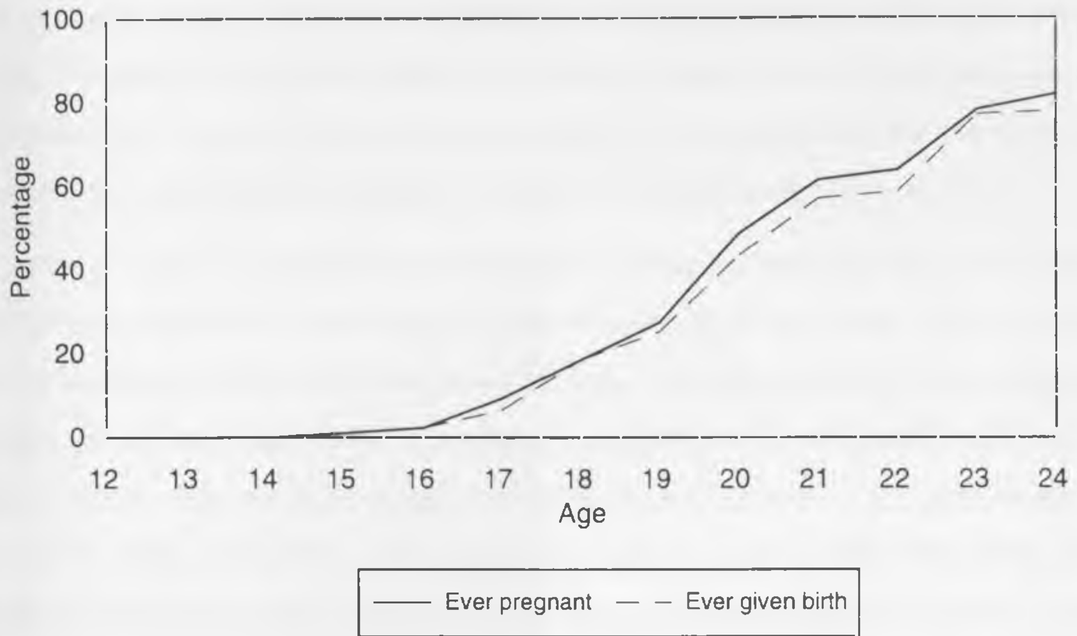
Source: 1995 Lesotho SMIS-WHS

Figure 2 presents the proportion of young women who ever had sex and ever used contraception by their current age. The figure shows that Basotho women begin sexual activities around age 15. 50 percent of all young women had sex by age 19 and at the age of 24, almost 95 percent had experienced sexual intercourse. Of those who had never married at the time of the survey, 50 percent had experienced sex by age 21 and by age 24, 60 percent of them had ever experienced sex.

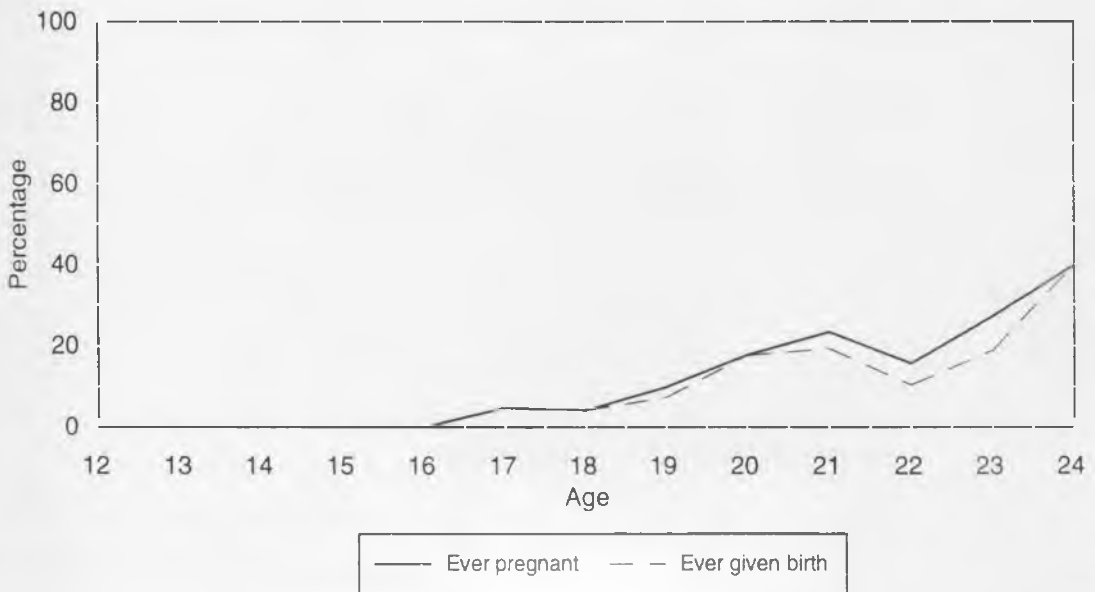
Considering ever use of contraception, the proportion ever using contraception also increases with age. The Lesotho SMIS-WHS also shows that 13.6 percent of all young women ever used contraception sometime before the survey. Restricting the sample to never-married women only, reduces the proportion to 4.6 percent. This supports the findings found elsewhere that unmarried adolescents hardly use contraception even if they are sexually active (see for example Kiragu and Zabin, 1995). However, it can be noted from Figure 2 that the gap between ever had sex and ever used contraception is narrower for never-married women compared with all women indicating that never-married young women are somewhat aware of the consequences of engaging in sexual relationships without the use of contraceptives.

'igure 3. Proportion of Adolescent Women Who Ever Became Pregnant and Those Who Ever Gave Birth by their Current Age.

a) All Adolescents:



(b) Never-married Adolescents:



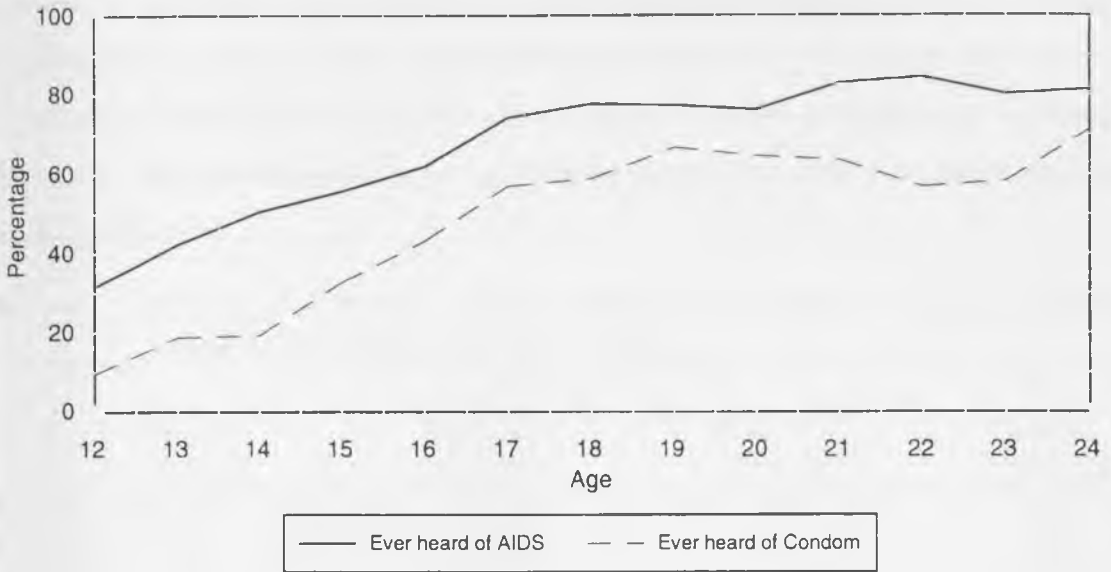
Source: 1995 Lesotho SMIS-WHS

The proportion of young women who ever become pregnant and those for whom one or ore of their pregnancies ended in a live birth is displayed in Figure 3. For all young women the oportion of both behaviours consistently increase with age . About 80 percent of those aged 24 ıd ever become pregnant. The gap between the two lines, which is visible from age 19, gives an dication of pregnancies which were terminated prematurely by an abortion (either spontaneous or duced). The pattern is somewhat different for unmarried young women. Possibly poor reporting serious for these women but there is an obvious delay in both getting pregnant and giving birth. regnancy starts at age 17 and only about 40 percent had ever been pregnant by age 24.

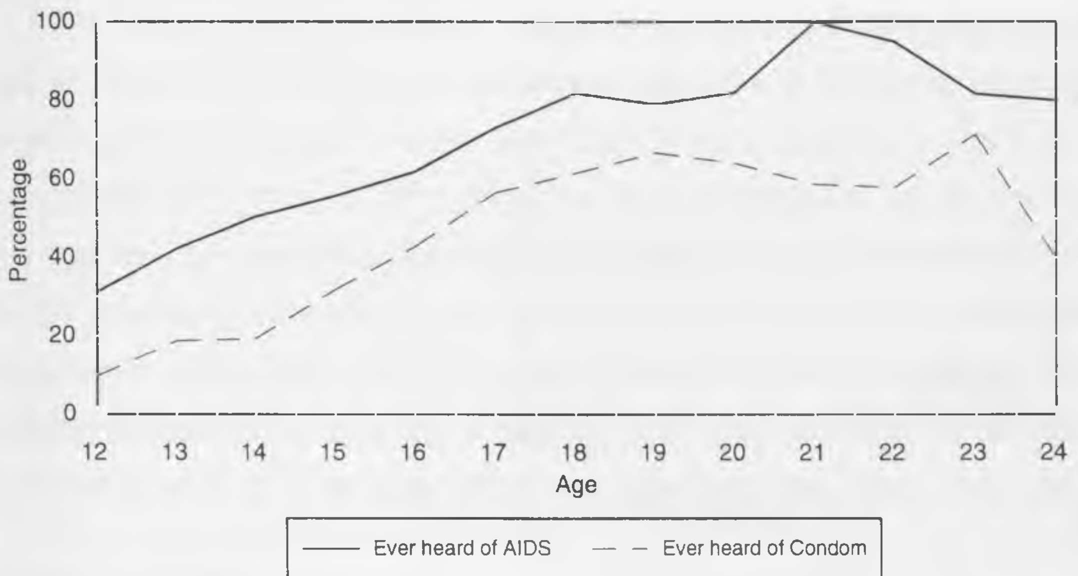
Finally, Figure 4 presents the proportion of young women who had ever heard of IV/AIDS and condoms by current age. The proportion of all young women and never married nes who had heard of HIV/AIDS is high and increases with age, becoming almost constant at lder ages. In both cases, knowledge of condoms is much lower than that of HIV/AIDS but also ıcreases with age. The overall percentage shows that about 45 percent of all young women had ver heard of condoms compared to 66 percent who had ever heard of HIV/AIDS. Even for the vhole female population, condom use is not one of the more popular methods in Lesotho (Tuoane nd Diamond, 1997). Perhaps, more effort needs to be given towards the promotion of condom as contraceptive method as well as for protection from infection.

gure 4. Proportion of Adolescent Women Who Ever Heard of HIV/AIDS and Condom by their Current Age.

) All Adolescents:



b) Never-married Adolescents:



Source: 1995 Lesotho SMIS-WHS

Overall, 13.6 percent of unmarried young women in Lesotho have ever had sex and only about 5 percent have ever used contraception. In addition, these adolescents tend to delay getting pregnant and giving birth and also have high knowledge of AIDS. It is in this regard that comparing the pattern of sexual behaviour of unmarried Basotho women aged between 15 and 24 with that of their counterparts in other countries in sub-Saharan is essential. This will throw some light as to how early or how late unmarried Basotho women engage in sexual activities when compared to other women. Three countries (two in the same region) are used for comparison and the results are presented in Table 1.

Table 1. Percentage distribution of never-married young women who ever had sexual intercourse by age and country of residence.

AGE	COUNTRY Lesotho[1] (N=856)	 Zimbabwe[2] (N=1,058)	 Botswana[2] (N=1,526)	 Liberia[2] (N=982)
15-24	20.8	22.9	78.0	78.3
15-17	8.7	10.9	45.9	64.1
18-19	26.9	25.1	86.1	87.2
20-21	38.8	39.6	97.1	97.1
22-24	55.7	58.0	97.9	97.3

Source: 1 1995 Lesotho SMIS-WHS
2 Gage-Brandon and Meekers, 1993 (using 1986-1989 DHS data)

Table 1 shows that in all countries, the percentage of young women ever having sex increases with age and the overall shows that Lesotho and Zimbabwe have the lowest percentage of unmarried young women having sex between ages 15 and 24 where less than a quarter in this age range are sexually active. The rates are higher for Botswana and Liberia. At age 24, less than 60 percent of unmarried young women in both Lesotho and Zimbabwe had ever had sex but almost all of those in Liberia and Botswana in the same age range had ever experienced sex. This therefore gives an indication of lower rates of sexual activities for unmarried women in Lesotho which are to a large extent comparable to that of their counterparts from Zimbabwe. The Basotho still have strong cultural practices which discourage women from engaging in premarital sexual activities.

5. Timing of First Sex

This section examines the timing of first intercourse. The first approach to this analysis examines how soon or late girls in Lesotho initiate sexual activities in relation to age at menarche. Age at menarche marks the physiological readiness to conceive a child while age at first intercourse

defines the beginning of risk of pregnancy and infection. The mean age of menarche recorded was around 14 years and that of intercourse 19. Table 2 shows the difference between reported age at first intercourse and reported age at menarche. It is observed from the table that a small proportion (2.8 percent) of young women initiate sex before menarche and 7.2 percent of those who ever had sex reported their age at first intercourse equal to their age at menarche. The majority (77 percent) initiate sexual activities between one and five years after menarche. In fact, there are a substantial number of young women (13.4 percent) who reported the difference between age at first intercourse and age at menarche to be six years or more.

Table 2. Difference between reported age at first intercourse (AFI) and reported age at menarche (AM)

AFI-AM (in years)	No. of cases	Percent
< 0	18	2.8
0	46	7.2
1	67	10.6
2	100	15.8
3	113	17.8
4	116	18.3
5	89	14.1
6+	86	13.4
Total	635	100.0

Source: 1995 Lesotho SMIS-WHS

Next, Table 3 presents mean age at first intercourse according to a number of socio-economic variables. Administrative districts of residence have been categorized into four regions: Northern (Butha-Buthe, Leribe and Berea), Southern (Mafeteng and Mohale's Hoek), Mountains (Quthing, Qacha's Nek, Mokhotlong and Thaba-Tseka), and Maseru.

The mean is based on the proportion of women not yet involved in sexual activities at the time of interview by age. That is, the estimates represent the number of years a woman is expected to spend before having her first sexual intercourse during the first 24 years of her life if current age specific proportions remain stable. The overall mean age at first intercourse shows that young Basotho women generally start their sexual relations after age 18 and considering the unmarried ones only shows that on average they start after their 21st birthdays The differences between the categories of each variable are much wider for unmarried young women than they are for all young women. The variables which show some obvious differences in both cases are education and

whether or not a woman drink alcoholic drinks. Life-time migration status categories show differences for all young women only while apparent differences in categories of type of place of residence, region of residence, religion, knowledge of condom and whether or not a woman has heard of HIV/AIDS are only observed for unmarried ones.

Table 3. **Mean age at first intercourse (AFI), in years, for all young women and those were never married by selected background variables.**

Variable	All		Unmarried	
	Mean AFI	N	Mean AFI	N
Total	18.8	1815	21.2	1312
Type of place of residence				
rural	18.8	1424	21.9	1019
urban	18.9	391	20.1	293
Region of Residence				
Northern	19.1	696	21.1	527
Maseru	18.9	476	21.0	334
Southern	18.6	325	20.4	228
Mountain	18.7	318	22.3	222
Educational level				
illiterate	17.8	134	23.2	107
primary	18.4	1115	21.4	795
secondary & adult educ	19.5	461	21.4	334
other	19.6	104	20.1	76
Radio listening				
yes	18.8	1045	20.8	761
no	18.4	760	21.8	541
Life-time migration status				
non-migrant	19.7	794	21.0	707
migrant	18.1	741	21.1	374
missing	18.9	280	20.9	231
Religion				
Catholic	18.7	816	20.8	600
Anglican	19.1	200	21.5	147
Lesotho Evangelical	19.1	451	21.2	336
other & none	18.7	338	22.5	222
Drinking alcohol				
yes	16.3	128	17.0	83
no	19.0	1680	21.7	1222
Heard of HIV/AIDS				
yes	18.8	1187	20.8	807
no	18.8	625	22.3	503
Knowledge of condom				
yes	18.5	816	20.1	508
no	19.4	984	22.5	794

Source: 1995 Lesotho SMIS-WHS

Note: The sum for some variables may not add up to the total because of missing cases.

6. Multivariate Analysis of Factors Related with Age at First Intercourse

6.1 The Statistical Model

The dependent variable used in the multivariate analysis is the duration elapsed since the age at which a woman begins to be exposed to the risk of initiating sexual intercourse to either age at first intercourse (for those who ever had sex) or time of the survey (for those never had sex). Event history analysis was developed for the study of duration data such as those in this study. The simplest type of event history model is the Cox proportional hazards model (Cox, 1972), hereafter called Cox model. This can be written as

$$\mathbf{h(t) = h_0(t)\, e^{(BX)}}$$

where $\mathbf{h_0(t)}$ is a baseline hazard function, **X** is a vector of covariates, and **B** is a matrix of coefficients to be estimated. The Cox model supposes that there is some unknown baseline hazard function describing the process being analysed and that the effect of the covariates is to shift the hazard up and down proportionally. Therefore, the application of Cox model is based on the assumption of proportionality. We tested for non-proportional effects using goodness-of-fit test and this demonstrated that for all the covariates included in the analysis the assumption of proportionality was not violated.

6.2 Variables and the Sub-Sample Used

For married women, the major determinant of first sexual intercourse is marriage.[2] Because of this obvious reason along with the fact that the majority of women in the sub-sample are still not married and hence miss information for important variables referring to husband or regular partner, we excluded ever married women in this part of analysis.

The age at first intercourse used as the beginning of exposure is 12 years. We computed the dependent variable by subtracting 12 from the age at first intercourse (or the current age for censored cases). If the age at first intercourse or current age is also 12, we give the value 0.5 to

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[2] Majority of married adolescent women (over 70 percent) gave the age at first sexual intercourse the same as the age at first marriage.

avoid having exposure of zero which is not acceptable by the statistical package (EGRET) used. In other words, we assume that 0.5 years were spent, on the average, in age 12 before having sex or before survey date. The seven explanatory variables included in the Cox model which have been documented to be correlated with the timing of first sex are: type of place of residence, region of residence, migration status, religion, educational level, radio listening and drinking alcohol.

6.3 Results

The multivariate analysis was carried out so as to assess the relative importance of each variable when other variables are controlled. The results show that four variables are significant, indicating that they are the most important variables associated with timing of first sex, net of all other variables included in the model. These are region of residence, type of place of residence, whether drinking alcohol or not and level of education. These are presented in Table 4 which shows the estimated relative risks and 95 percent confidence intervals.

Table 4. Estimated relative risks and 95 percent confidence intervals for the factors related with age at first intercourse

Variable	Relative Risk	95% Confidence Intervals
Region of Residence		
Northern (rc)	1.00	-
Maseru	1.46**	1.06 - 2.01
Southern	2.18**	1.50 - 3.12
Mountain	1.17	0.71 - 1.93
Residence		
Rural (rc)	1.00	-
Urban	1.74**	1.273 - 2.39
Drinking alcohol		
No (rc)	1.00	-
Yes	4.09**	0.358 - 0.67
Educational level		
Illiterate	0.42*	0.169 - 1.03
Primary (rc)	1.00	-
Secondary & adult educ	0.76*	0.566 - 1.01
Other	0.91	0.642 - 1.29

Source: 1995 Lesotho SMIS-WHS

Note: rc stands for reference category

** significant at 0.05 level, *significant at 0.10 level

Unmarried young women residing in Maseru and the southern region are significantly different from those in the northern region (reference category) but no significant difference is observed for those residing in the mountainous region. The highest risk of exposure to sexual activities is observed for women in the southern region where the hazard rate is more than twice that of women residing in the northern region. For those residing in Maseru, the risk is almost one and half times higher than for those residing in the northern region. Regional differences in early onset of first intercourse have been hypothesised to be related to overall teenage fertility in each region (Odynak, 1994). Regions with above average overall teenage fertility are predicted to also show earlier onset of intercourse. This is proved to be the case in Lesotho because both Maseru and the southern regions are observed to have the highest percentages of unmarried young women who have ever given birth (5.7 percent in the southern region and 5.1 percent in Maseru compared to 2.7 percent and 3.6 percent in the northern and mountainous regions, respectively).

In the case of type of place of residence, unmarried young women living in the urban areas are 1.7 times higher at the risk of the onset of sexual intercourse than those living in the rural areas. This supports the hypothesis that urbanisation weakens the social control that has traditionally discouraged premarital sexual activity among young women, resulting in earlier experimentation of sex for those living in the urban areas.

Young women who drink alcohol have 4.1 times higher risk of experiencing sex compared with their counterparts who do not drink. This supports the syndrome of similar risk behaviours also observed among Kenyan adolescents (Kiragu and Zabin, 1993). Young people engaged in drinking alcohol (the same applies for smoking, attending discos etc) are more likely to experiment with sex than others who do not practise these behaviours.

Education is another important variable, significant at 10 percent level. Contrary to the belief that the increase in education among women is one of the most important factors associated with higher levels of premarital sexual activities, the data show that this is not always the case. Illiterate women have 60 percent less risk of experiencing sex compared to those with primary education while those with at least secondary education have 25 percent less risk of experiencing sex than those with primary education, indicating that those with primary education are more likely to experience sexual activities earlier than those who are illiterate and earlier than those with at least secondary education. The lower risk of those with at least secondary education compared to those

with primary education could be explained by the fact that achieving students (who go up to secondary education) are more likely to place high value on achievement and less interested in sexual relationships or, on the other hand, those with primary education could have been distracted from their studies by sexual relationships. In the case of those who are illiterate, they may not have yet been affected by formal education which has been charged with eroding cultural or familial constraints on premarital sexual relations (Cherlin and Riley, 1986 cited in National Research Council, 1993).

7. Discussion

This paper has discussed various aspects of the patterns of sexual behaviour among young Basotho women. Compared with Botswana and Liberia (other sub-Saharan African countries), unmarried women in Lesotho start sexual activities later, explained by the fact that Basotho still have strong cultural practices which discourage premarital sexual activities. A wide gap between ever having sex and ever using contraception is observed, thus putting young women at the risk of sexually transmitted diseases and unwanted pregnancies, particularly for unmarried women. This finding also highlights the need to provide family planning services to young women and improve their knowledge of reproductive health in order to reduce the likelihood of unwanted pregnancies. Although knowledge of HIV/AIDS among young women in Lesotho is high, knowledge of condom is relatively low. This is an indication of inadequate information they get on HIV/AIDS such that they may not know how to protect themselves from acquiring the disease and other sexually transmitted diseases.

Marriage is the most single factor related to age at first intercourse in Lesotho. The 1995 Lesotho Safe Motherhood Initiative - Women's Health Survey (SMIS-WHS) suggests that most married women begin having sex immediately after getting married. For unmarried young women, region and type of place of residence are some of the strongest variables related to age at first sexual intercourse. The results suggest that any policies geared to tackle the problem of premarital sex in Lesotho is likely to be effective if strategies are developed for each region separately, with more emphasis placed in Maseru and the southern region where unmarried women not only have higher risks of engaging in sexual intercourse but also higher rates of premarital pregnancy. In

addition, programmes aimed at replacing the weakening cultural practices in urban areas should be promoted through improved family life education.

Drinking alcohol is related to experiencing sex early among unmarried young Basotho women. It is not easy from the type of data we have to identify the behaviour which came first between drinking and initiating sex. But, we are convinced that any successful effort to discourage young women from drinking will most likely have impact on reducing the proportion of women having early premarital sex.

Contrary to the common belief that the spread of female education is one of the major factors causing an increase in the levels of premarital sexual activities, highly educated young women in Lesotho are less likely to initiate sexual activities than those with low education. Although this is a positive indication, there is room to raise further the level of literacy in the country. Though women in Lesotho, unlike in many African countries, appear to enjoy a greater access to education than men, a lot of them do not complete secondary education and very few continue their education beyond secondary school. Education does not only discourage women from having premarital sex but also encourages those who have experienced sex to use contraception and to choose the type of contraception they like (Tuoane and Diamond, 1997). Therefore, every effort must be made to encourage continuation of their education to secondary and higher levels of education.

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