

Factors Associated with Risky Sexual Behaviour Among Adolescents in Lesotho.

*T. J. Makatjane, M. Lebuso, T. 'Maseribane
and M. Mokhoro*

National University of Lesotho
Faculty of Social Sciences
P.O. Roma 180
Lesotho

Abstract

Since 1993 HIV prevalence in Lesotho has increased 5 fold making Lesotho the third highest HIV infected country in the world. The government of Lesotho has not only declared HIV pandemic a crisis, but several efforts have been made to curb the spread of the disease that include encouraging Basotho to know their status as well as requesting government departments to use 2 percent of their budget allocations towards mitigation against the disease. The latest HIV prevalence figures from the 2004 Lesotho Demographic and Health Survey suggest that more still needs to be done in order to reverse the spread of the disease. Using the 2002 Lesotho Core Welfare Indicator Questionnaire Survey (CWIQ) data the paper examined variables associated with risky sexual behaviour among Basotho adolescents. The results of the paper suggest that HIV programmes targeting girls should be different from those targeting boys. Results further indicate that HIV programmes might have to be district specific.

Introduction

HIV prevalence in Lesotho rose from about 4 percent in 1993 to 25 percent in 1999, 27 percent by the end of 2001 and it was 23.5 percent in 2004 making Lesotho the third highest HIV infected

country in the world (USAID, 2004; Ministry of Health and Social Welfare, 2005; Ministry of Health and Social Welfare, Macro International and Bureau of Statistics, 2004). Lesotho is known for its high male labour employed in South Africa which dates back to the first contact of Basotho with Europeans (Makatjane, 1994). Since male migration is known to be associated with high levels of HIV prevalence due to spouse separation among others (Chirwa, 1997; Lurie et al, 1997; Nunn et al, 1995; Pison et al, 1993; Basset et al, 1992) it might not come as a surprise that Lesotho has high HIV prevalence. The labour migration system which has helped to keep the fertility of Lesotho low and constant (Mpiti and Kalule-Sabiti, 1985.; Matabane, 1996; Timaeus and Balasubramanian, 1984; Sembajwe, 1985; and Makatjane, 1996) is proving to be a problem with respect to HIV/AIDS pandemic.

The surge in AIDS deaths has halted or reversed gains in life expectancy in many African countries. In Lesotho, life expectancy was nearly 60 years in 1995, but it has plummeted to 36 years by 2000, primarily due to AIDS-related deaths (World Bank, 2005; Carl Haub, 2007, Population Reference Bureau, 2007). HIV is also impacting negatively on the labour force of the country. In the education sector HIV prevalence is estimated to be high among teachers (World Bank, 2005) and this is a threat to the policy of universal primary education which the government has embarked on. The clothing and textile industry which employs a third of Lesotho's labour force and a significant foreign currency earner for the country (Bureau of Statistics, 2008) is also threatened. According to ALAFA study 43 percent of the clothing and textile workers were HIV positive which is about twice the national figure of 23 percent (ALAFA, 2008). There is no doubt the economic impact of HIV has far reaching consequences.

Due to the high level of HIV prevalence in Lesotho it is estimated that the number of orphaned and vulnerable children has nearly doubled, from 92,000 in 2003 to 180,000 in 2005, of which 100,000 were orphaned as a result of AIDS (Ministry of Finance and Development Planning, 2005). It is also noteworthy that the proportion of the population aged less than 25 years which is double orphaned increased threefold between 1996 and 2001 compared to what it was between 1986 and 1996 (Makatjane, 2007). The increase in the proportion of orphaned children in Lesotho is attributed to the high HIV prevalence rate which is seen as a threat to government's efforts to achieve the millennium development goals (Government of Lesotho, 2004). By 2010, orphans are expected to account for more than 25 percent of all children. The disease is forcing children to assume parental responsibilities such as heading household prematurely as well as leading to dropping out of school. While Lesotho has introduced free primary education, parental guidance is crucial in order for children to attend school and orphaned children lack that parental guidance.

As far back as 2000, the government of Lesotho had recognised that HIV/AIDS pandemic has social, economic and cultural implications. Consequently it developed the National Policy on HIV/AIDS Prevention, Control and Management to create a conducive environment for prevention of further spread of HIV/AIDS and to mitigate the adverse impact of the infected and affected individuals, families and communities. Lesotho government has further committed 2 percent of its ministerial budget allocations towards HIV/AIDS prevention and impact mitigation programme. Combating further spread of HIV continues to be one of the biggest challenges that face the country.

The Millennium Development Goals (MDGs, 2000) have set the global agenda geared at ending poverty by the end of 2015. The same Millennium Development Goals do allege that intervention through education, health, confronting the impact of HIV/AIDS and affording the population and youth in particular decent employment will go a long way in breaking the poverty cycle. It is important that Lesotho finds ways of harnessing the energy, force and dynamism of the youth in order to steer Lesotho towards sustainable development failing which youth without jobs can create a scenario for crime, violence and social unrest.

In an effort to encourage Basotho to take voluntary HIV tests, in 2004 the Prime Minister of Lesotho took an HIV test publicly. Despite efforts like these including those of NGOs within Lesotho and outside as well as those of the development partners of Lesotho, there is little evidence that the country is managing to stop further spread of HIV. It is imperative therefore that more research is carried out in order to find ways of perfecting policies and strategies that would help the country to achieve the objective of reversing the negative impact of the pandemic. The present research is one such an endeavour in augmenting knowledge with respect to factors associated with risky sexual behaviour.

Using the 2002 survey data, the present paper has a double objective. The first is to establish prevalence of risky sexual behaviour among Lesotho adolescents by different socio-demographic characteristics. Secondly the paper aims at identifying variables that are associated with engaging in risky sexual behaviour among adolescents in Lesotho. The 2002 survey data where respondents were asked whether they had engaged in sexual intercourse with a non-regular partner and whether in those engagement respondents used a condom,

provides an opportunity to investigate who are the adolescents who are more likely to engage in risky sexual behaviour. This is particularly so because the 2002 survey report did not go beyond the prevalence of engaging in sexual relations with a non-regular partner. Moreover, the report has not disaggregated adolescents from adults and the presentation is about all the respondents aged 15 years and above. Gaining more insights about risky sexual behaviour among adolescents can go a long way in helping policy makers in trying to formulate strategies or perfecting existing strategies aimed at combating further spread of the HIV. This is very important given that universal HIV/AIDS awareness does not translate into safe sexual behaviour among the population through the use of condoms or reduction of sexual relations with non-regular partners.

Data and Methods

The paper uses data from the 2002 Lesotho Core Welfare Indicator Questionnaire Survey (CWIQ). Out of 4873 adolescents (population aged between 15 and 24 inclusive), 1289 (27 percent) did not have information on whether they had engaged in sexual intercourse with a non-regular partner during the past 12 months prior to the survey while 847 did not have information on HIV transmission knowledge. This leaves 2737 respondents available for analysis. Details of the survey design and other important aspects of the survey are given in the 2002 Lesotho Core Welfare Indicator Questionnaire Survey (Bureau of Statistics, 2003).

Based on the question on known methods of how the virus that causes AIDS and HIV can be transmitted between two individuals and whether a healthy looking person could be HIV positive, a variable HIV knowledge was constructed. The variable took on the values of 0 for those who did not know

how the virus is transmitted, 1 for those who knew only one method and lastly 5 for those who knew all the four methods of transmission listed in the question and whether a healthy looking person could be HIV positive.

Mass media exposure was another variable for the study. Respondents residing in households possessing a working radio or TV were classified as respondents with access to mass media. Ideally the frequency of listening to the radio or watching TV would have been a better measure of indicator of exposure to mass media, particularly if such information is supplemented by frequency of reading newspapers. In the absence of this information residing in a household that posse a working radio was used.

Engaging in sexual intercourse with a non-regular partner within the past 12 months is used to measure risky sexual behaviour. All respondents aged 15 years and above were asked whether they had engaged in sexual intercourse with a non-regular partner within the past 12 months prior to the survey. The responses were coded 1 for those who reported sexual intercourse with a non-regular partner and zero otherwise. As indicated earlier, respondents who did not have information on this question were eliminated from the analysis. For a respondent to be considered as having engaged in risky sexual behaviour, the respondent must have had sexual intercourse with a non-regular partner without using a condom. Engaging in sexual intercourse with a non-regular partner without the use of a condom is taken as engaging in risky sexual behaviour. Respondents who did not engage in sexual intercourse with a non-regular partner and those who did but used a condom were classified as respondents who did not engage in risky sexual behaviour.

Based on previous research and the “authors” intuition, the following variables were identified as variables that could be associated with risky sexual behaviour;. They are sex, where males are likely to engage in risky sexual behaviour than females, age where the older the individual the longer the exposure to the risk of engaging in risky sexual behaviour; knowledge of HIV/AIDS where it is assumed knowledge will help individuals to act responsibly when engaging in sex or use of the condom when the circumstances dictate, education which facilitates knowledge about HIV/AIDS and how to protect oneself against infection, access to media through presents availability of a working TV or radio within the household where the individual is residing.

Both descriptive and multivariate methods of analysis are used in the paper. Descriptive analysis is used to describe risky sexual behaviour prevalence among adolescents by their characteristics and those of the households they reside in as well as those of the household head. Logistic regression is used to identify factors associated with risky sexual behaviour of adolescents. Three models are run; the first model is for both males and females while the other two are for males and females separately.

Characteristics of the Study Population

According to Table 1 there were more females (55.7 percent) than there were males (44.3 percent) in the study. Asked whether they had been away from home, 84 percent of the respondents had never left home while 13 percent had been away from home for less than 6 months and 3 percent had been away from home for 6 months or more. With regard to any contribution economically for the running of the household, only 16 percent was reported as contributing while 84 percent was not contributing.

According to the relationship to the household head more than half (56 percent) of the respondents were children of the head, a fifth (24 percent) were other relatives of the head, about seven in ten were either heads of households or spouses of the head while five in ten were non-relatives of the head. Age wise 54 percent of the respondents were aged 15-19 years while 46 percent were aged 20-24 years. According to marital status more than three quarters (78 percent) of the respondents were never married while about a fifth (22 percent) were ever married. Educationally slightly more than half (51 percent) of the respondents had completed primary education followed by a slightly less than a third (27 percent) with secondary education and slightly more than a tenth (12 percent) had completed senior secondary or better and a tenth (10 percent) had no formal education.

Residentially, two thirds (64 percent) of the respondents were residing in households headed by males while a third (36 percent) were residing in households headed by females. Slightly less than two thirds (60 percent) of the respondents were residing in rural areas while more than a third (40 percent) were residing in urban areas. A third (34 percent) of the respondents were currently in school while two thirds (66 percent) were not. Close to 80 percent of the respondents reported that they were not engaged in any economic activity while 20 percent reported that they were engaged in some economic activity. Regarding access to the media, 13 and 58 percent of respondents were respectively residing in households with a working TV and radio.

Table 1: Characteristics of the Study Population

Variable		Percent	Number
Sex	Male	46.2	1641
	Female	53.8	1909
Length of Absence	Less than 6 months	12.6	446
	6 months or more	2.8	98
	Never	84.7	3006
Any Contribution? Yes	16.1	572	
	No	83.9	2978
Relationship to Head	Head	6.8	241
	Spouse	8.0	284
	Other relative	24.8	880
	Non-relative	4.7	166
	Child	55.7	1979
Age	15-19	53.6	1902
	20-24	46.4	1648
Marital Status	Ever married	22.3	790
	Never married	77.7	2760
Educational Attainment	No education	9.7	343
	Primary	50.9	1808
	Secondary	27.4	971
	COSC	12.1	428
Currently In School	Yes	31.6	1122
	No	68.4	2428
Any Type of Work	Yes	21.1	750
	No	78.9	2800
Sex of Head	Male	63.9	2268
	Female	36.1	1282
Television Owned?	No	88.6	3146
	Yes	11.4	404
Radio Owned?	No	44.9	1593
	Yes	55.1	1957
Rural Urban Residence	Rural	63.9	2268
	Urban	36.1	1282

Prevalence of Risky Sexual Behaviour

Table 2 presents prevalence of risky sexual behaviour among adolescents for several background socio-demographic characteristics. According to the figures in Table 2 on the whole a tenth of the respondents were engaging in risky sexual behaviour while males were more prone to risky sexual behaviour than females. Respondents who reported absence from home were slightly more likely to engage in risky sexual behaviour than their counterparts that had never left home. Regarding whether respondents were contributing to the economic up keep of the household, 13 percent of those who reported that they were contributing were engaging in risky sexual behaviour compared to 11 percent of those who reported that they were not contributing.

Considering relationship to household head, the head recorded the highest prevalence of 16 percent followed by non-relatives at 14 percent prevalence and then children and other relatives at 12 and 11 percent respectively while spouse recorded the lowest prevalence of 5 percent. According to marital status, currently married reported the lowest prevalence of 8 percent while previously married respondents reported the highest prevalence of around 22 percent. Never married respondents reported the second highest prevalence of 12 percent. It would seem that, educationally speaking, there is a negative relationship between education and prevalence. Respondents with no formal education reported the highest prevalence of 23 percent followed by those with primary education at 12 percent. Those with secondary education or better; reported prevalence of less than 10 percent. There were only marginal differences in the prevalence between respondents by sex of the household head within which respondents were residing while respondents residing in rural

households reported a higher prevalence than those residing in urban areas.

According to district, Butha-Buthe, Qacha's Nek and Thaba-Tseka reported the lowest prevalence rate of less than 10 percent while Leribe, Quthing, Maseru and Mafeteng recorded the highest prevalence of at least 13 percent. The remaining districts reported a prevalence rate of between 10 and 11 percent. With respect to knowledge of HIV transmission, results in Table 2 suggest a negative correlation between knowledge and prevalence. Respondents with no knowledge of how HIV virus is transmitted or who know one method reported the highest prevalence of 12 percent and there after prevalence decreases with the increasing level of knowledge. Only 7 percent of those who know three or more methods were engaging in risky sexual behaviour.

Table 2: Risky Sexual Behaviour Prevalence by Background Variables: Lesotho 2002

		Prevalence (%)
Total		12
Sex	Male	15
	Female	8
Length of absence	Less than 6 months	14
	6 months or more	16
	Never	11
Any economic contribution to the household?	Yes	13
	No	11
Relationship to head	Head	16
	Spouse	05
	Other relative	11
	Non-relative	14
	Child	12
Age	15-19	10
	20-24	13
Marital status	Ever married	9
	Never married	12

Educational attainment	no education	23
	Primary	13
	Secondary	8
	COSC	6
Currently in school?	Yes	7
	No	12
Any type of work?	Yes	15
	No	11
Working Television in the household?	No	12
	Yes	08
working Radio in the household?	No	14
	Yes	10
Rural urban residence	Rural	13
	Urban	8
Sex of head	Male	11
	Female	12
Wealth index	1	15
	2	13
	3+	10
Housing Quality	1	13
	2	14
	3+	9

Risky sexual behaviour and HIV/AIDS knowledge

Table 3 presents risky sexual behaviour prevalence by several HIV/AIDS knowledge variables. According to the figures in Table 3, there is an inverse relationship between knowledge of HIV/AIDS and engaging in risky sexual behaviour among adolescents. Respondents declaring that they know how HIV virus is transmitted are less likely to engage in risky sexual behaviour while prevalence of risky sexual behaviour is highest among respondents who know fewer methods of HIV transmission. The opposite is the case among those who know three or more methods of HIV virus transmission. The same was true about knowledge that a healthy-looking person could be HIV positive where respondents with knowledge were less

likely to engage in risky sexual behaviour compared to those who did not know. Knowledge about a place where one can obtain a condom was also associated with lower prevalence of risky sexual behaviour.

Surprisingly there was no difference in risky sexual behaviour prevalence between respondents who had taken a HIV test in the past 12 months prior to the survey and those who did not. However, respondents who reported ever taking an HIV test were less likely to engage in risky sexual behaviour. Respondents who collected their HIV test results were also less likely to engage in risky sexual behaviour compared to those who tested but did not collect results or those who did not test at all. Respondents who did not take an HIV test because they did not think they were at risk had the same risky sexual behaviour prevalence as those who did not take the test but for other reasons. Respondents who did not take the test because they were scared of the results were more likely to engage in risky sexual behaviour than those who did not take the test for other reasons.

Table 3: Risky Sexual Behaviour Prevalence by HIV/AIDS Knowledge Variables: Lesotho 2002

		Prevalence (%)
Total		12
Know how HIV/AIDS is transmitted (declared knowledge)	no	13
	Yes	11
Number of known methods of HIV/AIDS transmission	0	12
	1	13
	2	10
	3+	8
Healthy-looking person could be infected	do not know	14
	No	12
	Yes	10
Had HIV test in the past 12 months?	Yes	12
	No	12

Ever had HIV test	yes	10
	No	12
Did not take HIV test because I do not think I am at risk	not applicable (have tested)	10
	Yes	12
	No	12
Did not take HIV test because I was scared of outcome	not applicable (have tested)	10
	Yes	13
	No	11
Did you collect HIV test results?	Yes	9
	No	13
	Never tested for HIV	12
Know a place where to obtain a condom	yes	11
	No	14
Can infected woman infect unborn child during pregnancy?	no	12
	Yes	9
Can an infected woman infect a breastfeeding child?	no	12
	Yes	7
Can one have HIV virus by having unprotected sex with an infected partner?	no	12
	Yes	11
Can one get the HIV virus through injection with an infected needle?	no	12
	Yes	9
Can one get a confidential test in your community?	do not know	13
	Yes	11
	No	11

To identify factors associated with risky sexual behaviour, three multiple logistic regression models were run and the results are presented in Table 4. All the variables used for the prevalence in Table 3 were used for the regression analysis. Stepwise was used to identify variable significantly associated with risky sexual behaviour and out of all the variables entered; only the variable in Table 4 were found significant. For the model for both males and females; following variables were found to be significantly associated with risky sexual behaviour: sex,

relationship to household head, age, marital status, education, current school attendance, household possession of a working TV, district and whether respondent is scared of testing for HIV. The model for males only identified education, current school attendance, district and whether the respondent is scared of testing for HIV while the model for females only identified relationship to head, marital status, current school attendance and district.

Table 4: Coefficients and Odds Ratios for the Relationship Between Risky Sexual Behaviour and Selected Variables, Lesotho 2002

		Both sexes		Males		Females	
		B	Exp(B)	B	Exp(B)	B	Exp(B)
Sex	Male	0.471**	1.601	na	na	na	na
	Female (RC)						
Relation of household head	Head	0.425*	1.529	na	na	0.915**	2.498
	Spouse	-0.642#	.526	na	na	-0.787*	0.455
	Other relative	0.072	1.075	na	na	0.010	1.010
	Non-relative Child (RC)	0.291	1.338	na	na	-0.375	0.687
Age	15-19	-0.324*	.723	na	na	na	na
	20-24						
Marital status	Ever married	-0.410*	.663	na	na	na	na
	Never married						
Educational attainment	No education	0.332*	1.394	0.264	1.302	na	na
	Secondary	-0.308*	0.735	-0.158	0.853	na	na
	COCS	-0.876**	0.416	-1.392**	0.249	na	na
	Primary (RC)						
Currently in School?	Yes	-0.636**	0.529	-0.698**	0.498	-0.820**	0.440
	No (RC)						
Unprotected sex with An infected partner?	Yes	-0.278*	0.757	-0.654**	0.520	na	na
	No (RC)						
Knowledge of HIV/AIDS	Yes	-0.211*	0.810				
	No (RC)						

Working radio in household	No	0.244*	1.276	na	na	na	na
	Yes (RC)						
Table 4 continued							
District	Butha-Buthe	-1.374**	0.253	-1.941**	0.144	-0.794#	0.452
	Leribe	0.211	1.235	-0.024	0.976	0.446	1.562
	Berea	-0.262	0.770	-0.585#	0.557	0.101	1.106
	Mafeteng	0.450*	1.569	0.389	1.476	0.383	1.467
	Mohale's Hoek	-0.157	0.855	0.073	1.076	-0.647	0.523
	Quthing	0.111	1.117	-0.306	0.737	0.706*	2.026
	Qacha's Nek	-0.810**	0.445	-0.727*	0.483	-0.909*	0.403
	Mokhotlong	-0.314	0.731	-0.056	0.945	-0.538	0.584
	Thaba-Tseka	-0.631*	0.532	-0.731*	0.481	-0.193	0.825
	Maseru (RC)						
Wealth index		-0.145*	0.865	-0.155*	0.857	na	na
Housing Quality		na	na	na	na	-0.200*	0.819
Constant		-1.257**		-0.240		-1.611**	

Discussion

At the bivariate level there are differences in risky sexual behaviour among adolescents by different background characteristics. Males were found to be more prone to engaging in risky sexual behaviour than females while education was found to be inversely related to risky sexual behaviour. This is the case in terms of educational attainment, whether the respondent was currently in school or having attained higher level of education was associated with lower risky sexual behaviour prevalence.

Exposure to unfamiliar environments such as being away from home for some length of time or working away from home seem to be associated with high levels of risky sexual behaviour prevalence. Respondents who had been away from home were more likely to have engaged in risky sexual behaviour than those who had never been away from home. The same was the case for those who were economically active or reported that they were contributing economically to the upkeep of the household in which they were residing. Exposure to sexual activity was not necessarily associated with high levels of risky sexual behaviour prevalence. Ever married respondents were less likely to engage in risky sexual behaviour and this was also the case among respondents reported as spouse to the household head. It was also apparent that high levels of poverty were associated with high levels of risky sexual behaviour prevalence.

Exposure to mass media in terms of residing in a household which possesses either a working radio or television was associated with lower levels of risky sexual behaviour prevalence except that difference in risky sexual behaviour prevalence was not that pronounced between respondents residing in households with a working radio and those residing

in a household without a working radio. If exposure to mass media helps people to refrain from engaging in risky sexual behaviour, it is not surprising that respondents residing in urban areas were less likely to engage in risky sexual behaviour relative to their counterparts residing in rural areas. As regards the sex of the household head, there were marginal differences in risky sexual behaviour between respondents residing in households headed by either a male or a female.

It is apparent from Table 3 that some respondents were afraid to take a HIV test because of fear of the results since they were engaging in risky sexual behaviour. The high risky sexual behaviour prevalence among respondents who tested for HIV and did not collect the results and those who did not test because they were scared of the results does suggest that some respondents do suspect that they are positive due to their engagement in risky sexual behaviour hence their reluctance to test or collect results when they have tested.

As correctly indicated in the 2002 survey report, changing sexual behaviour of the population is key in the successful prevention of the spread of HIV/AIDS within communities.

Conclusion

It is apparent that at the bivariate level both declared and assessed knowledge of HIV translate into less engagement into risky sexual behaviour among Basotho adolescents. Educational attainment of the individual and whether the individual is currently at school are associated with low prevalence of engaging in risky sexual behaviour. Exposure to mass media as well as high levels of wealth and housing quality as well as urban areas are associated with low levels of risky sexual behaviour engagement.

After controlling for other variables, current district of residence and whether one is currently in school are important predictors of risky behaviour for both boys and girls. Educational attainment, wealth index and whether HIV virus can be transmitted through unprotected sex with an infected partner were identified as predictors of risky behaviour among boys only while among girls relationship to the household head and housing quality were identified. Age, marital status, declared knowledge of HIV and access to a working radio were identified as predictors of risky behaviour only when boys and girls were together.

Recommendations emanating out of the results are that separate HIV programmes for boys and girls should be developed. District specific HIV programmes should also be designed. Improving the quality of Basotho through poverty reduction as well as access to quality housing would go a long way in creating a conducive environment for reduction of engaging in risky sexual behaviour among adolescents in Lesotho.

References

- ALAFA** (2008) *HIV Zero-Prevalence Study Report* www.aibs.gr/2/php/publications.php?lang=en Accessed on the 10th November 2007
- Bassett, M. T., Latif, A. S. Katzenstein, D. A and Emmanuel, J. C.** (1992) "Sexual behaviour and risk factors for HIV infection in a group of male factory workers who donated blood in Harare Zimbabwe". *Journal of Acquired Immune Deficiency Syndrom*, 5, No. 6.
- Bureau of Statistics** (2003) *Lesotho Core Welfare Indicators Questionnaire CWIQ Survey 2002*. Maseru: Bureau of Statistics.
- Bureau of Statistics and Macro International** (2004), *Lesotho Demographic and Health Survey*. Maseru: Bureau of Statistics.
- Carl, H.** (2007) World Population Data Sheet (Washington DC: Population Reference Bureau) http://www.prb.org/Articles/2007/623HIV_AIDS.aspx Accessed 7 September 2007
- Chirwa, C. J.** (1997) "Migrant Labour, Sexual Networking and Multi-partnered sex in Malawi". *Health Transition Review Supplement 3 to vol. 7*.
- Government of Lesotho**, (2004) *Report on the Proceedings of the National Symposium on Leadership for Results: Towards Accelerating Implementation of the National Response to HIV/AIDS Pandemic*. Maseru: Morija Printing Works.
- Lurie, M, A. Harison, D. W. and Karim, S. A** (1997) "Circular migration and sexual networking in rural Kwazulu/Natal: Implications for spread of HIV and other STDs". *Health Transition Review Supplement 3 to vol. 7*.

- Makatjane, T.** (1996a) "Fertility Trends in Lesotho". *Lesotho Social Science Review*.
- Makatjane, T. J.** (1994) "The future of Labour Migration: Its Demographic Implications for Lesotho". *Lesotho Social Sciences Review vol. 1 (2):26-38*.
- Makatjane, T. J.** (1996b) "Fertility Trends in Lesotho". *Lesotho Social Sciences Review vol. 1(2):35-44*.
- Makatjane, T. J.** (2007) "Poverty, Gender and Education in Lesotho". *Review of Southern African Studies Vol. 5 (1 & 2):62-88*.
- Matabane, M.** (1996) *Lesotho's Fertility Trends: 1961-1991. Can We Learn Anything from Botswana's Experience?* Working Papers in Demography, Paper No 23 Demography Unit Department of Statistics, National University of Lesotho, Roma Lesotho
- Ministry of Finance & Development Planning.** (2005) *Lesotho Population Data Sheet*. Maseru: Government of Lesotho.
- Ministry of Health and Social Welfare.** (2007) *2005 HIV Sentinel Survey Report*. Maseru: Government of Lesotho.
- Ministry of Health and Social Welfare.** (2005) *Lesotho Demographic and Health Survey*. Maseru: Bureau of Statistics
- Mpiti, A. M. and I. Kalule-Sabiti** (1985) *The Proximate Determinants of Fertility in Lesotho*. WFS Scientific Reports. No. 78 Voorburg, Netherlands. International Statistical Institute.
- Nunn, A. J., Wagner, H. U Kamal, AKengeya-Kayondo, J. F. and Mulder, D. W.** (1995) Migration and HIV-1 seroprevalence in a rural Ugandan population. *AIDS* 9.

- Pison, G., Le Guenno, B. Lagarde, E. Enel, C. and Seek, C.** (1993) "Seasonal migration: A risk factor for HIV in rural Senegal". *Journal of Acquired Immune Deficiency Syndrom*, 5, No. 6
- Population Reference Bureau** (2007) *World Population Highlights 2007: HIV/AIDS*.
- Sembajwe, I.** (1985) *Lesotho Demographic Profile and Research Agenda*. Working Papers in Demography, Paper No 1 Demography Unit Department of Statistics, National University of Lesotho, Roma Lesotho
- Timaeus, I. and Balasubramanian, K.** (1984) *Evaluation of the Lesotho Fertility Survey 1977*. WFS Scientific Reports. No. 58 Voorburg, Netherlands: International Statistical Institute.
- USAID**, 2004. *Country Profile: HIV/AIDS – Lesotho*. The Synergy Project. www.synergyaids.com on Accessed the 15 August 2007
- World Bank** (2005) "Building on Free Primary Education, Primary and Secondary Education in Lesotho: A Country Status Report". African Region Human Development Working Paper Series No. 101 Washington D. C.