Exploring social factors that inform the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho

by

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DECLARATION

I, Tsotang Raymond Moeketsi, declare that this dissertation titled "Exploring social factors that inform the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho" is my own original work, with all sources properly cited and acknowledged through complete references. I confirm that I have submitted the dissertation to originality checking software and that it meets the accepted standards for originality. Additionally, I declare that I have not previously submitted this work or any part of it for any other qualification or to any other higher education institution.

Tsotang R. Moeketsi

17/12/2025

Date

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ABSTRACT

Adolescent girls in Lesotho and other countries with high human immunodeficiency virus (HIV) prevalence need urgent action to increase enrolment in pre-exposure prophylaxis (PrEP), which remains low and limited. Studies reveal that many adolescent girls in Lesotho continue to fall pregnant unintentionally and are infected with HIV despite mitigation efforts by the government. For instance, the Government of Lesotho, in collaboration with other stakeholders, has enhanced the availability of sexual and reproductive health services in all 10 districts of the country and made family planning services accessible to adolescents aged 12 years and older without parental consent. However, there are concerns that such access to contraception might inadvertently undermine HIV prevention efforts. In Lesotho, little is known about how adolescent girls who use family planning services navigate the risk of HIV. Consequently, this study aimed to address this gap by examining the social factors that contribute to the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho, by employing the Health Belief Model and the Theory of Planned Behaviour theoretical framework.

Using a purposive sampling approach, 12 adolescent girls aged 18 and 19 years were recruited to participate in the study. Data were generated through semi-structured face-to-face and telephonic interviews and were analysed using Braun and Clarke's (2006) six-stage thematic analysis method. The findings demonstrate that social factors such as fear of stigma, conflating PrEP with antiretroviral therapy, and negative attitudes and beliefs towards PrEP discourage its use, lower the perceived HIV risk among adolescent girls, and reduce tolerance for possible side effects.

This study makes recommendations to healthcare service providers to create safe spaces to reduce stigma and to avoid moralising language when developing health promotion messages that target peer and reference groups, as many adolescents tend to base their decisions on the opinions of their peers or significant others. The contribution this study makes to existing knowledge pertaining to adolescent health and HIV is that much of the feared stigma faced by adolescent girls is anticipated, and that stigma, whether anticipated or experienced, discourages the uptake of HIV prevention and treatment services or their continuation.

Keywords: PrEP uptake; adolescent girls; family planning; social factors; HIV prevention; donor-funded projects; Berea; Lesotho.

KAKARETSO (SESOTHO ABSTRACT)

Baroetsana naheng ea Lesotho le naheng tse ling tseo sekhahla sa ts'oaetso ea HIV se phahameng haholo, ba hloka mehato e potlakileng ea ho nyolla sekhahla sa ts'ebeliso ea litlhare tsa PrEP ho thibela HIV, se tlase ha joale. Liphuphutso li sibolla hore ho ntse ho ena le lipalo tse holimo haholo tsa baroetsana ba kenang bakhachaneng bo sa reroang le ho fumana ts'oaetso ea kokoana-hloko ea HIV ho sa natse mehato ea mmuso ea ho fokotsa sekhahla se joalo. Mohlala, mmuso oa Lesotho o ntlafalitse phumaneho ea lits'ebeletso tsa Bophelo bo botle ba thero ea Malapa le thibelo ea HIV literekeng tsohle. Mmuso o fetisitse melaoana e lumellang baroetsana ba lilemo tse leshome le metso e mmeli ho fumana lits'ebeletso tsa thero ea Malapa ntle le tumello kapo tsebo ea motsoali. Le ha ho le joalo, sena se tlisa ngoangoareho ea hore phumaneho ea lits'ebeletso tsena ka sebopeho sena e ka nna ea fokotsa ts'ebeliso ea lisebelisoa tse reretsoeng ho thibela mafu a likobo, a kenyelletsang HIV. Liphuphutso tse entsoeng Lesotho mona li shebane le maikutlo a basebeletsi ba phano ea lits'ebeletso tsa Bophelo malebana le ts'ebeliso ea PrEP, tsebo, ekasitana le thahasello ea baroetsana ba likolong tse phahameng ea ho sebelisa PrEP, mme ha ho tsebahale hore na baroetsana ba sebelisang lithibela-pelehi bona na ba its'ireletsa joang khahlanong le HIV. Ka lebaka leo, boithuto bona bo leka ho koala sekheo sena ka ho fuputsa mabaka a susumetsang sekhahla se tlase sa ts'ebeliso ea PrEP har'a baroetsana ba sebelisang lits'ebeletso tsa thero ea Malapa seterekeng sa Berea, Lesotho.

Ka ho sebelisa mokhoa o tobileng oa ho khetha batho ba nkang karolo boithutong bona, baroetsana ba leshome le metso e mmeli (12) ba lilemo tse leshome le metso e robeli (18) le leshome le metso e robong (19), ba ile ba khethoa ho nka karolo. Boithuto bona bo fumane lintlha ka ho botsa lipotso tse hlophisitsoeng ka kotlololoho ho baroetsana ka sebele, le ka mohala, mme thematic analysis ea Braun le Clarke (2006) e ile ea sebelisoa ho lekola, ho utloisisa, le ho hlalosa likarabo tsa baroetsana bao. Boithuto bona bo fumane hore mabaka a amanang le ho ts'aba sekhobo sa ts'ebeliso ea PrEP, ho nka PrEP joalokaha e ka ke litlhare tsa HIV kapo li ARV, maikutlo le litumelo tsa batho malebana le PrEP, li nyahamisa baroetsana ho ka sebelisa PrEP, mme li nyenyefatsa bo-kotsi ba HIV ho baroetsana, kaha li susumetsa ho nyahamela ho nka lipilisi ka mehla le ho se mamelle litla-morao tsa ts'ebeliso ea PrEP.

Likhothaletso li fanoe malebana le basebeletsi ba phano ea lits'ebeletso tsa Bophelo ho tla ka melaetsa e mecha e tobileng lihlopha tsa metsoalle ho feta ho shebana le motho ka bo mong,

ka ha baroetsana ba bangata ba etsa liqeto tsa bona ba ipapisitse le hore na maikutlo a metsoalle ea bona ke a feng malebana le taba e itseng. Boithuto bona bo tsoelapele ho eketsa tsebo mabapi le litaba tse amang bacha le HIV, hore sekhobo se nahanoang se ts'oana le sekhobo se phetsoeng.

Mantsoe a bohlokoa: Ts'ebeliso ea PrEP; baroetsana; thero ea malapa; lintlha tsa likamano; thibelo ea kokoana-hloko ea HIV; merero e ts'ehelitsoeng ke bafani; Berea; Lesotho.

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AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centers for Disease Control and Prevention
CoHiP SEC	Comprehensive High Impact Community-Based HIV Prevention, Testing and Treatment Initiation for Sustained Epidemic Control
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, Safe
FHI	Family Health International
FSW	Female sex worker
FTC	Emtricitabine
GRID	Gay-related immune deficiency
HBM	Health belief model
HIV	Human immunodeficiency virus
IUD	Intrauterine device
LAPCA	Lesotho AIDS Programme Coordinating Authority
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and other
LMIC	Low- to middle-income countries
MSM	Men who have sex with men
NAC	National AIDS Commission
PCP	Pneumocystis carinii pneumonia
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TDF	Tenofovir disoproxil fumarate
TPB	Theory of planned behaviour
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
US	United States
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1:
INTRODUCING A STUDY ON SOCIAL FACTORS THAT INFORM THE LOW UPTAKE OF PRE-EXPOSURE PROPHYLAXIS (PrEP) AMONG ADOLESCENT GIRLS

1.1 Introduction and background to the study

Lesotho is one of the countries that is most severely affected by the human immunodeficiency virus (HIV) in the world, with the second-highest prevalence recorded globally (Low et al., 2019). It is estimated that among 2.1 million people in Lesotho, 281 693 Basotho of all ages were living with HIV in 2022, and that number slightly decreased in 2023 to an estimated 271 396 (United States [US] President's Emergency Plan for AIDS Relief [PEPFAR], 2022; Government of Lesotho, National AIDS Commission [NAC], 2024). According to Velardez (2024), young women in Lesotho are at a higher risk of HIV infection than men their age, facing more than three times the likelihood of a positive HIV diagnosis compared to men. The NAC (2024) reports that in 2023, 160 000 women were living with HIV, 17.5% of whom were girls in school aged 15 to 19. Compounding this public health crisis is the unmet need for family planning services that help to prevent early and unplanned pregnancy among adolescent girls. In 2018, the Lesotho Multiple Indicator Cluster Survey reported that at least 1 304 adolescent girls aged 15 to 19 were either pregnant or had already given birth (Bureau of Statistics, 2019). This is significant because teenage pregnancy can result in devastating social and health complications for the teen mother and child, particularly when maternal deaths in Lesotho are among the highest in the world, standing at approximately 618 per 100 000 live births (Mukurunge, Rapitse & Bhila, 2023).

Consistent with global efforts, Lesotho has invested in bold initiatives to enhance the sexual health of adolescents through the delivery of highly subsidised comprehensive sexual and reproductive health (SRH) services (Khaile, 2024). As a result, approximately 280 000 women in Lesotho were using hormonal and barrier birth control methods to prevent pregnancy in 2021, particularly pills, injections, and condoms (Mohai et al., 2023). Debates concerning the association between contraceptive use and HIV acquisition have been ongoing. Although the global findings remain largely inconclusive, some American studies report little to no correlation, while others suggest an increased risk of HIV transmission among contraceptive users (Hofmeyr, Singata & Sneden, 2014; Morrison et al., 2015; Wall et al., 2015; Curtis et al.,

2020; Byrne et al., 2016; Kiarie, 2017). Lee et al. (2023) argue that although dual method use – combining HIV prevention and contraceptives to prevent both sexually transmitted infections (STIs) and pregnancy – could help to mitigate HIV risk and unintended pregnancies, it remains underused. To understand the low utilisation of HIV prevention services among adolescent girls and young women seeking contraceptive care, this study explored the social factors that influence the reluctance of adolescent girls to take up PrEP.

PrEP entails the use of antiretroviral (ARV) drugs by HIV-negative individuals who are at risk of contracting HIV to prevent infection (Restar et al., 2017). The Centers for Disease Control and Prevention (CDC, 2025a) recommends the use of PrEP for people who are not already infected with HIV but might be exposed to it, often through sex or injecting drugs. One of the five pillars recommended by the Joint United Nations Programme on HIV/AIDS (UNAIDS) for the effective mitigation of HIV transmission, Truvada for PrEP, is a once-daily oral ARV medication that contains the active ingredients tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC). It has been reported to significantly reduce the risk of HIV acquisition when administered on a daily basis (Nsuami & Witbooi, 2021).

The role of PrEP in preventing HIV is especially critical among adolescents. Ramraj et al. (2023) highlight a heightened risk of HIV acquisition among adolescent girls and young women between the ages of 15 and 24, with around 310 000 new cases recorded worldwide in 2018, 86% of which were from sub-Saharan Africa. In 2020, the global total of adolescents living with HIV was 1.75 million, with over 70% of them residing in low- to middle-income countries (LMICs) (Goldstein et al., 2023). For this reason, PrEP should be more accessible to mitigate the threat of HIV among individuals who are at high risk, particularly those who engage in unsafe sexual practices (Xu & Zhan, 2022; Frimpong et al., 2022). However, Ajayi et al. (2019) argue that knowledge and use of PrEP among adolescents remain quite limited.

Alongside HIV, adolescent girls also face early and unwanted pregnancies. Van Dyk, Tlou and Van Dyk (2017) argue that rates of unintended pregnancy and HIV among young people are primarily due to low levels of condom use. A study conducted in South Africa examined adolescents' risk perceptions of HIV and unplanned pregnancies and found that most prioritised preventing unplanned pregnancies over preventing HIV when choosing family planning methods (Methazia, Bessenaar & Baum, 2024). Methazia et al. (2024) found that preventing HIV is often not a significant concern for many adolescents, and that despite numerous interventions intended to address unplanned pregnancy and HIV, young people continue to

experience high rates of both. According to the Lesotho Multiple Indicator Cluster Survey, the contraceptive prevalence rate was estimated at 63% among the 6 453 women who participated in the survey (Bureau of Statistics, 2019). Against this background, this study explored why adolescent girls who use family planning services have little interest in taking up PrEP, even when their contraceptive use indicates irregular condom use and exposure to HIV. The study employed a qualitative design and conducted interviews with 12 adolescent girls aged 18 and 19 to identify the social factors that inform low PrEP uptake among this demographic. The study further employed an integrated framework combining the Health Belief Model and the Theory of Planned Behaviour to examine how adolescents' attitudes toward PrEP and their perceived risk of HIV infection influence their PrEP uptake behaviour.

1.2 Global historical overview of the human immunodeficiency virus (HIV)

Identifying exactly when the devastating disease now known as HIV and acquired immunodeficiency syndrome (AIDS) first emerged proves difficult. Globally, scientific debates about the earliest cases of HIV date back to the early 1980s (Blattner, 1991; Katrak, 2006). A review article by Chopra, Ni and Lim (2019) discusses reflections and future expectations regarding HIV/AIDS, which emphasises the consensus among scientists that HIV probably originated around the late 1930s in West Africa, likely from a chimpanzee species that infected hunters. In his book, *The Origins of AIDS*, Jacques Pépin (2021) argues that while it may be naïve to assume HIV originated in Africa based on the prevalence rates among adults at that time, evidence suggests that HIV had been present in parts of Central Africa for some time, even though this does not necessarily mean it originated there. Despite ongoing debates about the origins of HIV, this paper recognises the zoonotic nature of the disease, specifically its evolution from the simian immunodeficiency virus, which mainly affects non-human primates, such as monkeys (Klatt, Silvestri & Hirsch, 2012; Sharp & Hahn, 2011).

In 1981, the United States of America (USA) encountered a peculiar disease that would change history forever. Reports surfaced of a rare pneumonia called pneumocystis carinii pneumonia (PCP) among an increasing number of gay men, along with an unusual cancer called Kaposi's sarcoma (Van Dyk et al., 2017). Chopra et al. (2019) note that, at that time, little was known about this mysterious illness, its causes, potential treatments, or preventive measures, which made it impossible to predict its future impact. In medical circles, the disease was referred to as PCP, but it was also known as GRID, or gay-related immune deficiency (Chopra et al., 2019).

As the disease spread to drug users and immigrants from Haiti in the USA, it was officially named AIDS in 1982 (National Academy of Sciences and Committee on a National Strategy for AIDS, 1986). The following year, researchers identified HIV as the virus responsible for AIDS (Van Dyk et al., 2017). Similar cases emerged in Europe among immigrants from sub-Saharan Africa, with investigations revealing heterosexual transmission (Quinn, 2021). To date, over 88.4 million people worldwide have been infected with HIV, and 42.3 million have died from AIDS-related causes (UNAIDS, 2024).

The World Health Organisation (WHO, 2024b) describes HIV as a virus that attacks and weakens the immune system by targeting white blood cells known as T-cells or CD4 cells. If untreated, HIV reduces the number of these cells, which increases the risk of opportunistic infections (Velardez, 2024) and leads to the advanced stage known as AIDS (CDC, 2025b). Studies show that HIV can spread through bodily fluids such as blood, semen, breast milk, and vaginal fluids, and can also be transmitted from mother to child (WHO, 2024b). Van Dyk (2008) notes that AIDS is not a single disease but a group of conditions arising from the immune system's failure to fight infections caused by HIV.

Vissers et al. (2008) note that behavioural changes, such as reducing the number of sexual partners and using barrier methods during high-risk exposure, have helped to slow HIV's spread in many regions. These measures will likely remain crucial until a vaccine is developed. However, given HIV's global prevalence, there was an urgent need for new, effective, and safe prevention strategies. While messages promoting abstinence, fidelity, and consistent condom use are helpful, their impact as primary prevention measures has been limited (Tetteh et al., 2017). Accordingly, on 16 July 2012, the US Food and Drug Administration approved Truvada, a once-daily combination of TDF and FTC, for PrEP use in HIV-negative individuals at high risk of sexual transmission (Holmes, 2012). TDF, alone or with FTC, was chosen for PrEP due to its effectiveness in inhibiting HIV replication, its safe profile, high resistance barrier, and minimal side effects (Bekker et al., 2016; Zalewski, Jabłońska & Mikuła, 2009). Moreover, oral FTC-TDF PrEP has shown excellent safety, with negligible impacts on kidney function, bone health, and pregnancy outcomes.

PrEP initiation was primarily aimed at lowering HIV risk among high-risk groups, especially men who have sex with men (MSM), due to their heightened vulnerability to STIs (Freeborn & Portillo, 2018; Dave, 2024). Demart and Gérard (2022) note that a few years after its introduction in the USA in 2012 and Europe around 2016 to 2017, PrEP use was largely

influenced by gender, with most users being MSM. To this effect, daily oral PrEP was found to be very effective at preventing HIV transmission among queer, bisexual, gay, and other MSM (Grant et al., 2010; Aidoo-Frimpong et al., 2025). In 2015, however, PrEP was also recommended for all individuals at significant risk of HIV, including HIV-negative MSM, transgender people, heterosexual men and women, adolescents, and people who inject drugs (Bekker et al., 2016; Fu et al., 2021). Wu et al. (2024) revealed that, although PrEP is highly effective in reducing HIV risk, men need at least two doses per week to reach 99% efficacy, whereas women require seven doses weekly for the same level of protection.

While many at high risk of HIV infection take PrEP daily, the WHO (2025) also advocates for an alternative approach called intermittent, or event-driven, dosing. This method follows a 2-1-1 schedule around sexual activity: two doses taken two to 24 hours before sex, then one dose daily for two days after. Significant progress has been made in developing long-acting HIV prevention methods. For example, a Stage 3 PURPOSE 1 study in South Africa and Uganda tested a twice-yearly lenacapavir regimen, which showed 100% efficacy in preventing HIV in women and adolescent girls (Xu & Zhan, 2024). The effectiveness of this regimen for MSM will be determined soon.

1.3 Historical overview of HIV in Lesotho

HIV and AIDS are significant public health concerns in many countries, including Lesotho (Xavier, Mokgatle & Oguntibeju, 2023). Lesotho reported its first HIV case in 1986, notably later than in other regions around the world: West Africa in the 1930s, St. Louis, USA, in 1969, Norway in 1976, and South Africa in 1983 (Belle, Ferriera & Jordaan, 2013; Chopra et al., 2019; Van Dyk et al., 2017). In 1987, the Government of Lesotho, through the Ministry of Health and Social Welfare's Division of Disease Control, established a National AIDS Prevention and Control Programme, which marked the beginning of Lesotho's efforts to address HIV (Government of Lesotho, NAC, 2007). However, by 1993, approximately 4% of the population (1 901 793) was already infected, and since then, the virus has spread rapidly, reaching 30% in 2002 (Loewenberg, 2007; Olowu, 2025). This rising prevalence rate led His Majesty King Letsie III to declare the epidemic a national disaster in 2000 (Belle et al., 2013). Meanwhile, in South Africa that same year, President Thabo Mbeki wrote a letter to world leaders to express his disbelief in the notion that HIV causes AIDS (Fassin & Schneider, 2003). In the early years following the first confirmed case in 1986, up until the early 1990s, Lesotho's response to the surging rates of HIV was disorganised. This changed in 2001 when the Lesotho

AIDS Programme Coordinating Authority (LAPCA) was established to coordinate national efforts against HIV/AIDS (Government of Lesotho, NAC, 2007). However, LAPCA achieved very little success during its existence due to challenges related to insufficient support and was eventually abolished and replaced by the NAC in 2005, in line with the global "Three Ones" principles aimed at establishing one coordinating authority, one action framework, and one monitoring system (World Bank, 2004).

Kabuya et al. (2023) reported that antiretroviral therapy (ART) was introduced for the first time in Lesotho in 2004. In May of the same year, the Senkatana ART Centre was established as the first public health facility in Lesotho to pilot ART, inspired by the legend of "Moshanyana oa Senkatana[1]" (meaning Senkatana's little boy), to address the rapid rise of the HIV and AIDS epidemic (Elizabeth Glaser Pediatric AIDS Foundation, 2015). By 2006, while other Southern African countries were still hesitant to permit nurses to initiate ART, Lesotho had already approved and adopted this practice as a formal part of the Lesotho National Treatment Guidelines in 2008 (Cohen et al., 2009). During this period, the government launched a nationwide Know Your Status campaign, which increased the number of Basotho who knew their HIV status from 50 000 in 2004 to over 240 000 in 2007 (WHO, 2008; Government of Lesotho, Ministry of Health and Social Welfare, 2011). Although the government first introduced prevention of mother-to-child transmission (PMTCT) programmes in 2003 to prevent mother-to-child transmission of HIV, the Minimum PMTCT Package was launched in 2007 as an expansion measure to provide all the necessary ARV medications for mothers and children during pregnancy, delivery, and the initial days following birth for women who gave birth at home (McDougal et al., 2012).

In 2012, the Government of Lesotho launched a nationwide voluntary medical male circumcision campaign aimed at reducing the transmission of STIs and HIV among men by at least 60% (Skolnik et al., 2014). The same year, according to Mugomeri et al. (2017), 12% of the national budget was allocated to HIV/AIDS mitigation and treatment, which highlighted Lesotho's prioritisation of SRH rights in its national agenda. By 2016, Lesotho became the first country in sub-Saharan Africa to implement the WHO's "Test and Treat" approach, which called for universal ART initiation for all persons living with HIV, regardless of their CD4 count (Schwitters et al., 2022). The NAC (2018) further indicates that until the fiscal year

[1] The legend of Senkatana tells of a monster that ate every person and animal in the village, leaving only one pregnant woman alive. She later gave birth to a son and named him Senkatana. When he grew into a young man, he defeated the monster, freeing all the people and animals the monster had swallowed (Swanepoel, 2024).

2015/2016, the Government of Lesotho remained the principal funder of HIV response interventions. However, between 2016/2017 and 2017/2018, the US government emerged as the most significant contributor to HIV prevention initiatives in Lesotho. A recent analysis of HIV trends in Lesotho shows that while there has been a decreasing trend in new infections and overall prevalence, the country still faces a substantial disease burden on a global level (Mupeta, 2024). According to UNAIDS (2023), the HIV prevalence among adults aged 15 to 49 was estimated at 18.5%. Additionally, data from Statista, as discussed by Elflein (2024), show that Lesotho ranks second worldwide with an 18.5% prevalence rate, behind Eswatini at 25.1%, far surpassing countries that encountered HIV earlier.

The demographic profile of the population in Lesotho indicates that women bear a larger burden of HIV, with young women aged 15 to 24 years being almost four times more likely to acquire an HIV infection than young men of the same age (Velardez, 2024; Schwitters et al., 2022). Chester-Hopkins (2021) notes that deeply rooted patriarchal attitudes among Basotho contribute to the increased vulnerability of women to HIV, due to the power dynamics in sexual relationships, which in part account for the high rates of infections among young women. Furthermore, Van Heerden et al. (2020) explain that early sexual activity, irregular use of condoms, sexual abuse, age-mixing sexual relationships, substance use, and poverty are key drivers of the high infection rates in Lesotho. A review by Schwitters et al. (2022) also confirms that age is an important factor, with adolescents often being victims of sexual intercourse involving older men, as the risk and prevalence of HIV increase with age among males.

It was imperative to provide this brief history to appreciate the strides taken over time since the first identification of a positive case of HIV in Lesotho. The country has adopted many approaches to effectively manage HIV and AIDS, and although the prevalence remains high, progress has started to shift due to Lesotho's relentless determination to combat AIDS. This historical account emphasises the necessity for the government to continue seeking new ways to reduce the risk of HIV among the Basotho people. Previous efforts have not been in vain, but they have not eradicated the HIV pandemic as anticipated. Therefore, it is important to demonstrate that, by drawing lessons from past experiences and building on those successes, strengthening the healthcare response could further advance the fight against HIV/AIDS. Mainstreaming PrEP and ensuring that it is widely available and accessible to all sexually active individuals may significantly impact the health outcomes of all sexually active Basotho, particularly adolescent girls.

1.3.1 The protection of sexual and reproductive health (SRH) liberties in Lesotho

In addition to participating in high-risk HIV behaviours, young women in Lesotho also face the burden of early and unintended pregnancies (Mohai et al., 2023). Sobane (2024) observes that the rate of adolescent pregnancies in Lesotho is higher than in most sub-Saharan African countries, estimated at 19%, more than half of which are unintended. Similarly, condom use among adolescent populations in countries with high HIV prevalence, such as Lesotho, remains low (Gutiérrez & Trossero, 2021; Nguyen et al., 2021). Maselinyane, Nyangu and Nyoni (2024) argue that unprotected sex is frequently the single most likely factor for unplanned pregnancy and HIV infection among adolescents. The rising prevalence of HIV and unintended pregnancies appears almost unavoidable, as Aventin et al. (2021) show that close to half of sexually active adolescents in Lesotho did not use condoms consistently in 2019. Recent studies indicate that adolescent birth rates remain among the highest in southern Africa, at 92.7 per 1 000 girls aged 15 to 19, largely because girls have limited access to contraceptives and youth-friendly services, alongside persistent cultural stigma against contraceptive use (Mwami, 2004; WHO, 2023a).

Acknowledging these issues, the Lesotho government has long expressed its commitment to improving SRH rights. All citizens of Lesotho have the right to achieve the maximum standard of physical and mental health, including access to family planning or reproductive health services, as provided for by the Constitution of Lesotho (1993). Building on this foundation, the government implemented the National Population Policy in 1994, which aimed to integrate a wide range of family planning methods into the healthcare system to ensure that all health facilities in the country could provide sterilisation, intrauterine devices (IUDs), injectables, and adequate information dissemination (Tuoane, Madise & Diamond, 2004). Although not immediately effective, this policy represented a significant shift towards an approach to family planning and population management that prioritised human rights in Lesotho. Later frameworks, including the National Health Policy of 2011 and the National Health Strategic Plan 2018 to 2023, have continued to reiterate this focus on promoting universal access, equity, and quality in family planning services in both rural and urban contexts (Government of Lesotho, Ministry of Health, 2021).

These additional efforts to improve SRH outcomes are also evident in the National Health Policy (2017), which promotes universal access to comprehensive family planning services and information. As part of these efforts, the Lesotho National Family Planning Guidelines

(Government of Lesotho, Ministry of Health, 2021) further ensure that adolescents aged 12 and above have access to family planning and SRH services without parental consent. This policy enables adolescents, who are among the most vulnerable groups concerning HIV and unintended pregnancies, to make informed and independent decisions about their reproductive health. The 2021 guidelines also emphasise a human rights-based approach, where accessibility, informed choice, and non-discrimination are essential principles. They promote the integration of family planning and HIV services and support a community-based approach, especially in the geographically challenging highlands where access to facilities is limited. Additionally, the guidelines endorse task sharing with trained nurses and community or village health workers to improve the availability of a wide range of methods (injectables, implants, or emergency contraceptive pills) across the country (Government of Lesotho, Ministry of Health, 2021).

However, even with the policy and programme measures taken to address service uptake issues, challenges in accessing and using family planning services for SRH persist. Despite initiatives such as the SRH Rights and HIV Linkages Project (United Nations Population Fund [UNFPA] in East and Southern Africa, 2011), DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, Safe), PMTCT, Test and Start, and other community-based interventions (Velardez, 2024) to support SRH among adolescents, uptake of PrEP remains low. To address gaps in knowledge, the Ministry of Health developed the Life Skills-Based Sexuality Education curriculum for secondary schools to increase access to age-appropriate SRH education among adolescents (Government of Lesotho, Ministry of Education and Training, 2019). However, obstacles such as stigma and unreliable access to services continue to hinder advancements in adolescent SRH outcomes in Lesotho. Furthermore, Khaile (2024) asserts that many national frameworks are gender-blind and lack social inclusion strategies, thus catering only to rural adolescents, persons with disabilities, and out-of-school youths. This underscores the importance of continued efforts to ensure that family planning services are equitable, gender-responsive, and tailored to the different needs of all young people in Lesotho.

1.4 Problem statement

It has been almost 40 years since the first case of HIV was identified, yet Lesotho still grapples with high levels of HIV among adolescent girls, despite the prevention measures that the country has taken (Government of Lesotho, NAC, 2024). Although PrEP has been included as part of Lesotho's national HIV prevention and SRH guidelines, uptake among adolescent girls

is significantly lower compared to their high risk for HIV acquisition (Chebet, McMahon, Chase et al., 2023). Evidence from a hospital-based study in Lesotho that assessed PrEP awareness found a significant gap between the availability of PrEP and its use among adolescent girls. While 71% of 152 young people aged 18 to 24 were aware of PrEP, only 12.5% had ever used it (Lekhutla & Taderera, 2025; Nonyana et al., 2022). The 2024 Lesotho Annual State of the AIDS Response report also revealed that PrEP coverage is notably below target, with only 31 229 people accessing it out of a target of 70 841 (Government of Lesotho, NAC, 2024). Evidently, the uptake of PrEP remains low among adolescent girls in Lesotho, despite their vulnerability to HIV.

Although the national guidelines promote the integration of PrEP into family planning service provision, actual integration remains inconsistent, and the uptake of services in these settings remains low among adolescents (Ekholuenetale, 2025; Nonyana et al., 2022). Numerous studies in Lesotho have explored various dimensions of PrEP. While some have investigated the factors that influence the acceptance and decline of PrEP and levels of knowledge, others have explored the perceptions and attitudes towards PrEP among service providers and users (Chebet, McMahon, Tarumbiswa et al., 2023; Lekhutla & Taderera, 2025; Geldsetzer et al., 2022; Nonyana et al., 2022; Karletsos et al., 2020; Masenyetse et al., 2023). However, research is lacking on PrEP uptake among adolescent girls who utilise family planning services in Lesotho. Local literature (Chebet, McMahon, Tarumbiswa et al., 2023; Nonyana et al., 2022) suggests that adolescents' willingness to take up and adhere to PrEP is heavily reliant on support from peers, how the community perceives PrEP, and the judgement attached to its use. These social factors are under-investigated in integrated family planning settings. There is a need to understand how social factors, such as the fear of PrEP stigma and subjective norms, as per the Theory of Planned Behaviour, inform the reluctance among adolescent girls to use PrEP. The aim of this study was therefore to explore the social factors that inform the low uptake of PrEP among adolescent girls using family planning services in Berea, Lesotho.

Furthermore, although national guidelines recommend integrating PrEP into family planning clinics, implementation remains inconsistent. As a result, little is known about the experiences of adolescents with these integrated services in practice (Nonyana et al., 2022). Adolescent girls may find it difficult to see PrEP as a relevant prevention option due to structural and social barriers, such as a lack of youth-friendly contraceptive counselling, limited campaign visibility, and ongoing moral stigmatisation of young women's sexuality, which discourage PrEP use. This creates a persistent disconnect between high contraception use and low PrEP uptake,

which leaves girls at risk of HIV infection despite improved pregnancy prevention. Given this gap, the study aimed to explore how social factors such as stigma, beliefs, perceptions, and the attitudes of peers and the community influence the low PrEP uptake among adolescent girls who access family planning services in Lesotho. The findings of the study have the potential to inform interventions to improve service uptake among adolescents, better integrate HIV prevention with family planning services, and guide policy and programme efforts to enhance Lesotho's response to HIV prevention among adolescent girls and young women.

1.5 Rationale for the study

Lesotho has made significant progress in meeting the demand for contraceptives among sexually active Basotho. The 2023 to 2024 nationwide survey, which included 6 413 women aged 15 to 49 in Lesotho, found that 67% of married women and 71% of unmarried women used some form of family planning method (Government of Lesotho, Ministry of Health, 2024). Through national policy, the country has improved access to family planning services by allowing adolescent girls from the age of 12 to seek contraceptive services without parental consent (Government of Lesotho, Ministry of Health, 2021). While this policy may protect adolescent girls from inadvertent disclosure and potential service denial by parents, concerns regarding disinhibition arise. Derefinko et al. (2020) argue that increased contraceptive use might unintentionally lower condom use for STI prevention among adolescents, thereby risking a situation where adolescent girls might engage in riskier sexual behaviours under the assumption of protection against pregnancy.

It was important to undertake this study to understand how adolescent girls who use family planning services navigate HIV prevention, given their vulnerability to it. The exposure of adolescent girls to HIV is driven by behavioural risks such as early sexual encounters, having multiple partners, irregular and non-use of condoms during sex, and age-disparate relationships (McClinton Appollis et al., 2022; Toska et al., 2020; Orindi et al., 2020). Another nationwide survey involving 6 453 women found 560 new HIV infections among girls aged 10 to 19 and 1 300 among those aged 15 to 24 in 2023 (Government of Lesotho, NAC, 2024). These figures add to the already high statistics of adolescent girls and young women living with HIV in Lesotho. The NAC (2024) indicates that in 2023, there were 9 800 adolescents aged 10 to 19 living with HIV, 5 600 of whom were adolescent girls. Additionally, among young people aged 15 to 24, an estimated 19 000 were living with HIV in the same year, with women accounting

for 13 000 of these cases. This demonstrates the stark reality of the risk of HIV acquisition among adolescent girls in Lesotho.

Demonstrably, despite ongoing prevention efforts, new HIV infections continue to occur among adolescent girls. This study seeks to generate new insights into why adolescent girls, whose engagement with pregnancy prevention services can heighten their vulnerability to HIV, remain reluctant to use PrEP as an HIV prevention method. In Lesotho, little is known about whether any of the new HIV infections include adolescent girls who use family planning services. This study did not aim to uncover this, but rather sought to understand the social factors that discourage them from using PrEP as an effective HIV prevention method. Although the literature in Lesotho on young women's willingness to use PrEP remains limited, even less attention has been given to those who may be exposed to heightened HIV risk through their engagement with pregnancy prevention services and who nonetheless demonstrate reluctance to use PrEP. Considering policy recommendations to integrate PrEP into family planning services, the study aimed to determine why adolescent girls use family planning services but decline PrEP, assuming that both are delivered by the same service provider.

1.6 Research aim, objectives, purpose, and questions

1.6.1 Purpose of the study

This study recognises, as Murewanhema et al. (2022) argue, that adolescents constitute a significant portion of the sub-Saharan African population and are particularly affected by HIV. It investigated the reasons for the limited use of HIV prevention services, particularly PrEP, among adolescent girls aged 18 to 19 who use contraceptives in Berea, Lesotho. Globally, literature indicates a rise in HIV infections among this group despite the availability of prevention methods (Aguirrebengoa et al., 2020; Leshargie et al., 2022; Karim & Baxter, 2019). This study, therefore, explored the social factors that influence the uptake of PrEP among adolescents. Gaining this understanding will help to improve health outcomes for adolescent girls, as the findings will be shared with service providers involved in HIV/AIDS prevention and community reduction programmes across Lesotho. By identifying these factors and sharing the research findings, HIV prevention service providers may tailor their services to better resonate with adolescent girls and increase demand for PrEP.

1.6.2 Aim of the study

The aim of this research was to explore the social factors that contribute to the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho.

1.6.3 Objectives of the study

The objectives of the study were as follows:

- To explore how social stigma affects the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho.
- To investigate the beliefs and attitudes towards PrEP use among adolescent girls who use family planning services in Berea, Lesotho.
- To examine the misconceptions about PrEP among adolescent girls who use family planning services in Berea, Lesotho.
- To assess the limitations in the availability and accessibility of PrEP that restrict uptake among adolescent girls who use family planning services in Berea, Lesotho.

1.6.4 Research questions

The main question of this study was:

> What are the social factors that influence the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho?

The sub-questions were as follows:

- How does social stigma affect the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho?
- What are the beliefs and attitudes towards PrEP use among adolescent girls who use family planning services in Berea, Lesotho?
- What are the misconceptions about PrEP among adolescent girls who use family planning services in Berea, Lesotho?
- How can the availability and accessibility of PrEP be improved for adolescent girls receiving family planning services in Berea, Lesotho?

1.7 Methodological underpinnings of the study

The endeavour to derive meaning from the low uptake of PrEP among adolescent girls using contraceptions necessitated the employment of a qualitative research design. This approach was deemed well suited to this study because it explored the complexities of human experiences and perspectives, thereby constructing detailed meanings and nuances that numbers alone cannot capture (Lim, 2025). Framed within an interpretive phenomenological paradigm, the research explored how the lived experiences of adolescent girls and the subjective meanings they attribute to PrEP uptake inform their intention to use PrEP. The study involved semi-structured face-to-face and telephonic interviews with 12 adolescent girls who accessed family planning services at the Comprehensive High Impact Community-Based HIV Prevention, Testing and Treatment Initiation for Sustained Epidemic Control (CoHiP SEC) clinic in Berea, Lesotho. Semi-structured interviews were preferred over structured interviews because of the flexibility they offer participants to express their opinions fully, while allowing the researcher to gather richer insights on a topic through probing interesting and unanticipated responses. To ensure that all the participants understood the questions posed to them, an interview guide with open-ended questions was developed and carefully translated into Sesotho to guide the conversation and elicit nuanced opinions. Braun and Clarke's (2006) thematic analysis process was employed to analyse and interpret the collected data. Braun and Clarke's (2019) reflexive account on the use of thematic analysis guided the creative generation of codes and themes from the data, rather than merely finding them as if waiting to be discovered.

1.8 Definition of key concepts

1.8.1 Adolescent

Adolescence is a transitional phase of development that individuals experience as they grow from childhood to adulthood, characterised by biological changes and shifts in social roles between the ages of 10 and 24 (Sawyer et al., 2018). While this definition adapts the WHO's definition of adolescence, the WHO (2025) defines adolescence as an important period in human development, occurring between childhood and adulthood, specifically between the ages of 10 and 19. Khaile (2024) highlights that this period is crucial and often challenging, during which young people depend on families, peers, schools, and health services for support, guidance, accurate information, and essential skills to navigate the complex journey to adulthood. According to the Lesotho National Family Planning Guidelines (Government of

Lesotho, Ministry of Health, 2021), adolescence in Lesotho aligns with the WHO's (2025) definition, which states that an adolescent is a young person who has begun puberty but is not yet an adult, aged 10 to 19 years. Consequently, adolescents in this study were considered individuals at this developmental stage, aged 10 to 19. However, for data-generation purposes, this study focused solely on adolescent girls aged 18 and 19.

1.8.2 Family planning

The WHO (2023a) describes family planning as the ability of individuals and couples to plan and attain their desired number of children, as well as to regulate the timing and spacing of births, facilitated through contraceptive methods and treatments for involuntary infertility. Family planning refers to the process that enables people to predict and achieve the number of children they want and the timing; this is often realised through contraception, which is defined as any method that can prevent pregnancy (Dehlendorf et al., 2010). The Lesotho Planned Parenthood Association (2021) identifies several long- and short-term contraception methods available in the country: male and female condoms, the pill, IUD, Norplant, injectables, emergency contraception, and voluntary surgical contraception. The Lesotho National Family Planning Guidelines (Government of Lesotho, Ministry of Health, 2021) recommend the following contraception methods as most suitable for adolescents: male and female condoms, hormonal contraceptives, emergency contraceptive pills, IUDs, surgical methods, and withdrawal (coitus interruptus). For this study, the term "family planning" is used to denote contraceptives and birth control methods available to adolescent girls.

1.8.3 HIV

HIV is a virus that attacks and weakens the body's immune system to the point where it is unable to fight disease if not treated, thereby causing AIDS (WHO, 2024b; Van Dyk et al., 2017). The WHO (2024b) adds that HIV can be transmitted from mother to child during birth and from one person to another through bodily fluids such as blood, vaginal fluids, semen, and breast milk, but not through sweat or saliva.

1.8.4 PrEP

PrEP is an HIV preventive approach in which HIV-negative individuals take ARV drugs to prevent HIV infection, commonly provided as a once-daily pill (Restar et al., 2017). In this

study, the term “PrEP” refers only to oral PrEP, not the two-month injectable PrEP or lenacapavir (twice-yearly injectable).

1.9 Chapter layout

The dissertation contains the following chapters:

Chapter 1: The first chapter introduces the study by providing comprehensive background to give context to the global and local situations of HIV, as well as the efforts made by the country to address high HIV rates and unintended pregnancies among adolescents. The chapter also explores the research problem and outlines the rationale and objectives of the study. It presents the research questions and briefly discusses the methodological foundations of the study.

Chapter 2: The second chapter offers a critical review and analysis of the local and international literature on the uptake of PrEP among adolescent girls. It explores themes such as stigma related to PrEP, beliefs and attitudes towards its use, misconceptions about PrEP, and the availability and accessibility of PrEP for adolescent girls aged 18 to 19. Additionally, this chapter examines the theoretical framework utilised in the study.

Chapter 3: The third chapter outlines the research design and methods used in this study. It specifies the eligibility criteria for participant selection, explains the data-collection and -analysis processes, and addresses the ethical considerations involved in conducting the study. Finally, the chapter discusses how the trustworthiness and reliability of the research were ensured and outlines the researcher’s reflexive account.

Chapter 4: The fourth chapter presents the findings and analysis of the study. It provides an overview of adolescents’ experiences and motivations for using family planning services, with the aim to ascertain the risks they may be exposed to when using these services. The chapter then proceeds to present and analyse findings on adolescents’ interactions with PrEP, which are organised into five overarching themes: narratives of Basotho adolescent girls concerning family planning use; adolescent girls’ knowledge about PrEP in Berea; social and psychological factors that affect PrEP uptake among adolescent girls; the impact of stigma on the uptake of PrEP among adolescent girls; and how accessible PrEP is to adolescent girls in Berea. Lastly, the chapter discusses the findings and analysis.

Chapter 5: This fifth and final chapter summarises the findings as they pertain to adolescent girls and the low PrEP uptake in Berea, Lesotho. This chapter also makes recommendations for

future research endeavours, as well as for healthcare service providers. Lastly, the chapter discusses the study's limitations and details the researcher's concluding remarks.

1.10 Conclusion

Lesotho faces an extremely high HIV burden, particularly among adolescent girls who have access to effective prevention options such as PrEP but are not using them widely. This chapter demonstrated that among adolescent girls who use family planning services, the challenge lies not in the difficulty of accessing PrEP, but rather in the social aspects that contribute more significantly to the low uptake of PrEP among them. PrEP's acceptability and use are limited by fear of stigma, inadequate knowledge about PrEP, and moral views regarding adolescents' sexual activity. Even though national programmes promote the integration of family planning and HIV prevention, there are missed opportunities for integration during service provision. Sexually active adolescent girls who have access to contraceptives are therefore at risk of HIV. Evidence indicates that increasing PrEP uptake requires addressing broader social determinants, improving community education around PrEP, and creating stigma-free healthcare environments. This study sought to explore how social factors, specifically fear of PrEP stigma, attitudes, and beliefs, influence adolescent girls' decisions regarding PrEP use, with the intention to inform more integrated and adolescent-responsive HIV prevention strategies in Lesotho that will improve health outcomes for adolescent girls.

CHAPTER 2:
LITERATURE REVIEW

2.1 Introduction

While there have been significant improvements worldwide in SRH and HIV prevention, adolescent girls and young women remain disproportionately affected by HIV, especially in sub-Saharan Africa, where the incidence rate is among the highest in the world (Murewanhema et al., 2022; Admassu, Nöstlinger & Hensen, 2024). In light of this, PrEP has been shown to reduce HIV acquisition by more than 92% when used regularly, and has therefore emerged as an essential preventive option for this population (Sundareshan et al., 2024). Unlike condoms or partner-dependent techniques, PrEP offers a user-controlled strategy that enhances agency for adolescents who may have limited negotiating power in their relationships (Willie et al., 2020; Vasco & Crowley, 2022). Despite its proven ability to be used discreetly, PrEP uptake remains low among adolescent girls (Ndlovu, Dlamini & Shezi, 2025). To overcome this challenge, discussions around new delivery approaches, such as integrating SRH services, long-acting PrEP formulations, and peer-led initiatives, suggest that promoting adolescent-centred health services could enhance PrEP uptake among this demographic (Milimu et al., 2024; Admassu et al., 2024). This chapter reviews existing literature on factors that affect the use of PrEP among adolescent girls who utilise family planning services, both in local and international contexts.

This literature review chapter seeks to explore the use of PrEP alongside family planning, specifically contraception for adolescent girls and PrEP as an HIV prevention method. It emphasises that, despite a global increase in contraceptive use, adolescent pregnancy and HIV risk remain significant public health issues, particularly in sub-Saharan Africa. The chapter reviews evidence on contraceptive awareness, information sources, and reasons for use among adolescent girls, taking into account the complex social and cultural barriers that affect disclosure and sexual health communication. It also examines global and regional PrEP trends and highlights ongoing barriers such as stigma, misconceptions, negative attitudes, and limited access to HIV prevention. In particular, stigma rooted in moral, cultural, and gender norms is discussed as a major factor, along with misinformation and structural inequalities that hinder the uptake of PrEP. Ultimately, the chapter provides a foundation for understanding the complex behavioural, social, and systemic factors that influence adolescent girls' access to

family planning and HIV prevention services. Lastly, the chapter discusses the suitability and applicability of the health belief model (HBM) and the theory of planned behaviour (TPB) for understanding the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services.

2.2 Addressing early and unintended pregnancies among adolescents through improved access to contraceptives

Despite the overall decline in birth rates among adolescents, pregnancy among adolescent girls remains a critical global health concern, particularly in regions such as sub-Saharan Africa, Latin America, and the Caribbean, where 21 million girls fall pregnant annually, most of which are unwanted and unintended pregnancies (WHO, 2025; Choonara et al., 2024). The high pregnancy rate among adolescents is concerning on its own, but it becomes an even greater problem when only half of the 21 million pregnancies lead to birth (Amoadu, Hagan & Ansah, 2022). The WHO (2024) reports that more than half of the unintended pregnancies among adolescents end in unsafe abortions. Consequently, teenage pregnancy is a serious problem in LMICs. This issue is exacerbated by the fact that pregnancy among adolescents is often associated with high maternal mortality rates, with over 70 000 adolescent girls dying each year from pregnancy-related complications in sub-Saharan Africa (Kassa et al., 2018; Diabelková et al., 2023). This indicates an urgent need for SRH services for adolescents in severely affected regions, as unintended pregnancies among adolescent girls often lead to dropping out of school and missing educational opportunities, diminished job prospects, increased dependence, exposure to the risk of HIV and other STIs, and a heightened risk of poverty (Morris & Rushwan, 2015; Cartwright et al., 2019).

The following sub-sections discuss how adolescent girls become acquainted with family planning services, the reasons behind their use of family planning, and the integration of family planning services with PrEP. Section 2.2.1 discusses the links between PrEP knowledge and uptake and further explores where and from whom adolescent girls seek PrEP information. Section 2.2.2 discusses the motivating factors for PrEP use among adolescent girls, while Section 2.2.3 addresses the benefits of integrating PrEP into family planning services to improve PrEP uptake rates.

2.2.1 How adolescents learn about family planning services

The WHO (2023c) highlights the importance of comprehensive sexual education and accessible contraceptive options for adolescents as a way to promote safer sexual practices among young people. Tohit and Haque (2024) assert that countries that promote SRH and provide comprehensive sex education to adolescents tend to have lower rates of teenage pregnancies and STIs. A study that examined the use of contraceptive methods among adolescents in the USA found that contraceptive use increased significantly, although this rise was not necessarily a direct result of increased sexual activity but rather from improved access to contraceptive information (Lindberg, Firestein & Beavin, 2021). Malungane, Mudau and Tshitimbi (2025) concur that increased knowledge about contraceptives is an essential first step in initiating their use. However, research in sub-Saharan Africa shows that knowledge alone does not always translate into the uptake of services. For example, a quantitative study involving 553 adolescents in Botswana found that while most had knowledge of contraception, 63% of the respondents reported no immediate intentions to seek SRH services (Lawson et al., 2025). Similarly, a study among 433 adolescents in Umlazi, KwaZulu-Natal, South Africa, found that while 87% of the respondents were aware of contraceptives, only 44% used them (Hlongwa et al., 2021). Likewise, in Lesotho, a quantitative study involving 194 adolescents revealed that while 64.5% were aware of contraceptives, only one-third reported using them (Khiba & Nyangu, 2024).

Given the uneven uptake of contraceptive services around the world, it is important to identify where adolescents obtain SRH information, as these sources can shape their perceptions and influence the uptake of other health services, including PrEP. Atkins and Bradford (2021) describe how the USA utilises a two-pronged sex education system in public schools, which comprises abstinence-only and comprehensive sex education, to improve contraceptive knowledge and uptake among adolescents. For example, a quantitative study in the USA that assessed sources of contraception information among adolescents found that healthcare providers were the preferred sources of information, even though parents were the actual sources for contraceptives (Pleasants et al., 2024).

Conversely, in the United Kingdom (UK), while parents are influential sources of contraceptive information, Swedish and Irish adolescents are often embarrassed and reluctant to talk to them for fear of strong opposition (D'Souza et al., 2022). Instead, Cartwright et al. (2019) found that in many parts of Europe and Asia, adolescents often turn to peers, sexual partners, celebrities,

and community health workers for SRH information. In Germany, adolescents favour Internet sources for SRH information, which presumably contributes to the decline in contraception uptake following posts that express low confidence in medical caregivers in Europe (Vieth et al., 2022). In Thailand, however, adolescents primarily learn about contraception from school and the Internet, and least from health providers (Leekuan et al., 2022).

In sub-Saharan Africa, a study among homeless adolescents living on the streets of Ghana, the Democratic Republic of the Congo, and Zimbabwe found a heavy reliance on peer adolescents for health information. For many homeless adolescents, peer networks remain essential sources of information because they seldom access formal healthcare due to disparities in healthcare delivery, such as discrimination and stigma when seeking services (Hunter, Van Blerk & Shand, 2021). The WHO (2024) reports that adolescents in many parts of the world, not just the homeless, face difficulties accessing contraceptives even when they are available. This is due to fears of stigmatisation, a lack of privacy, financial constraints, and a lack of knowledge regarding where to obtain and how to properly use them. A study in Nigeria that assessed preferred information sources among adolescents found that peers were the most commonly preferred sources of information, surpassing parents and teachers (Agu et al., 2023). Although Molefe and Nyangu (2025) identified schools, community outreach initiatives, and mass media as ideal strategies to optimise contraceptive use among adolescents in Lesotho, Hellwig and Barros (2023) discovered that many adolescents relied on their friends and relatives for SRH information. For this study, it was important to ascertain the factors that lead adolescent girls to use contraceptive services, as these factors have the potential to expose users to the risk of HIV. Section 2.2.2 identifies and discusses such motivating factors among adolescents globally.

2.2.2 Factors that motivate adolescent girls to use family planning services

Adolescent girls are often motivated to use contraceptives by a combination of social, economic, and health factors, with the primary aim of preventing unintended pregnancies that could potentially disrupt their education and future financial independence (Moloi & Malapela, 2024). Although it was argued in Section 2.2.1 that contraceptive knowledge alone does not always translate into uptake, research shows that providing adolescents with accurate contraceptive information and access to services has been proven to increase uptake among adolescents (Bhatt et al., 2021; Egbende et al., 2024; Government of Lesotho, Ministry of Health, 2021). This indicates that adolescent girls may be motivated to utilise contraceptive services to prevent unintended pregnancy primarily because such services are available.

For many adolescent girls, their contraceptive use is motivated by the most attractive attributes of the method, such as ease of use, perceived invasiveness, and the ability to control utilisation or discontinuation (D'Souza et al., 2022; Berglas et al., 2021; Ti et al., 2022; Adedini & Omisakin, 2023). Family and friends also often play a critical role in influencing contraceptive choices. Calhoun et al. (2022) highlight that peer networks are crucial in informing contraceptive decisions, as peer support often normalises contraceptive use and reduces the potential stigma that discourages adolescents from seeking services. Empowering adolescent girls also contributes to the uptake of contraceptive services, as empowered adolescent girls are better placed to utilise these services, particularly in societies where cultural norms and relationship power dynamics are substantial factors in determining contraceptive use, as well as where confidential, youth-friendly, and non-judgemental services are available (Durante et al., 2023; D'Souza et al., 2022; Lassi et al., 2024; Moloi & Malapela, 2024).

In the USA, factors such as personal preference, bodily autonomy, and access to counselling services motivate adolescent girls to use family planning methods (Brittain et al., 2018). Berglas et al. (2021) found that adolescents often favour low-efficacy methods that are easier to use and discontinue at will, such as condoms and emergency contraceptive pills, due to their flexibility and the autonomy they offer, which aligns with their lifestyles. However, Ti et al. (2022) contend that concerns about costs and contraceptive side effects related to weight gain, mood fluctuations, and future fertility may discourage many users. Adequate counselling and support may therefore help to keep many adolescents on modern pregnancy prevention methods. Interestingly, Durante et al. (2023) established that providing counselling services and removing cost barriers significantly improved the uptake of long-acting reversible contraception among American adolescents. These findings reinforce broader evidence that affordable, supportive, confidential, and youth-friendly services are critical to the uptake and continued contraceptive use for adolescents in the USA (Durante et al., 2023; D'Souza et al., 2022).

Adolescents in Europe, similar to those in the USA, consider privacy and autonomy to be essential when selecting a contraception method (Michaud et al., 2020). However, motivations for contraceptive use vary widely across European countries. D'Souza et al. (2022) found that adolescents in the UK and Ireland often ignore contraceptive use in stable relationships until a pregnancy scare occurs. As a result, many adolescent girls begin using contraception primarily out of fear of unintended pregnancy. Although pregnancy prevention remains the core motivation, a cross-sectional study in Europe reported that adolescents in countries such as the

UK, France, Switzerland, and Australia use contraceptive methods to regulate menstruation and improve acne (European Parliamentary Forum, 2022; Ti et al., 2022). This indicates that this group uses contraceptives more for perceived benefits such as acne control and stopping menstruation, relative to pregnancy prevention. In Asia, conversely, since the 1970s, China has enforced strict birth control policies that restrict most families to one child, which has led to the widespread use of contraceptive methods as a means of compliance (Wang, 2023). In other Asian countries, adolescents use family planning methods due to issues that affect their mental health (Purwatiningsih et al., 2025). This means that individuals who experience psychological distress, who may not be in a position to make such decisions for themselves, are initiated on contraception to prevent unwanted pregnancies resulting from sexual abuse.

Likewise, in sub-Saharan Africa, adolescent girls predominantly use contraceptive methods to prevent early and unwanted pregnancies (Mbadu Muanda et al., 2018). Their desire to avoid pregnancy, however, stems from multiple yet interrelated factors. Many adolescent girls use family planning methods out of fear of shame, dishonour, and the stigma associated with unintended adolescent pregnancy, which affects both the girls themselves and their parents (Mbadu Muanda et al., 2018; Zulu et al., 2024). Ketye et al. (2024) found that mothers sometimes encourage adolescent girls to use contraceptives, fearing the economic burden on the family and the societal judgement that comes with pregnancy out of wedlock. In rural areas, adolescent girls use contraceptives because they fear pregnancy from sexual abuse, which could also lead to child marriages, as some communities require a man to marry a girl he has impregnated (Ajayi & Ezegbe, 2020; United Nations Children's Fund [UNICEF], 2021). Furthermore, a qualitative study involving 33 adolescents in Ekurhuleni, South Africa, found that family planning methods are often preferred in abusive relationships when male partners refuse to use condoms (Moloi & Malapela, 2024).

2.2.3 Improving PrEP uptake through the integration of HIV prevention into family planning services

There is a valid concern that increased contraceptive use among adolescent girls might unintentionally affect condom use, which is crucial for preventing STIs (Derefinko et al., 2020). Research highlights a concerning pattern of reduced condom use, especially in countries with high HIV rates (Gutiérrez & Trossero, 2021; Nguyen et al., 2021). This underscores the need for comprehensive approaches that promote both pregnancy and HIV prevention, rather than treating them separately. Given these patterns and the persistently high HIV infection rates

among young women worldwide, integrating PrEP into family planning services could improve access to and uptake of PrEP among sexually active women who are already using SRH services (Bhavaraju et al., 2021). Additionally, integration is feasible since the short-acting contraceptives sought by adolescent girls require the same clinic visit schedule as PrEP (Bhavaraju et al., 2021). Nonyana et al. (2022) reiterate that offering PrEP in family planning settings could effectively increase access to HIV prevention for at-risk populations and emphasise that expanding PrEP access for adolescent girls and young women should be a priority to achieve epidemic control.

There are discernible benefits to integrating PrEP into family planning services. Primarily, integrating PrEP and family planning services would ensure that adolescents who present for family planning receive counselling on comprehensive HIV prevention, including PrEP where appropriate, while those who present for HIV prevention services are also counselled on and offered family planning services (Mugwanya et al., 2021). Adolescents often underutilise HIV prevention and family planning services because of the perceived and anticipated societal stigma, particularly the fear of being labelled promiscuous for seeking contraceptives or HIV prevention services (Mbadu Muanda et al., 2018; Chittamuru et al., 2020; Moloi & Malapela, 2024). However, integration reduces HIV-related stigma for adolescents who fear judgement and have not disclosed their PrEP use, and reduces access costs by making services available in the same facility (Narasimhan et al., 2019).

In Lesotho, the integration of HIV prevention and family planning services is potentially an effective way to enhance SRH outcomes for women and girls. The National Health Strategic Plan 2018 to 2023 emphasises the integration of family planning into HIV and AIDS services as a national policy priority, aiming to improve access and continuity of care across health systems in Lesotho (Government of Lesotho, Ministry of Health, 2019). Similarly, the UNAIDS Lesotho Country Report for 2020 to 2021 underscores the progress made in integrating HIV prevention and family planning services and scaling up the provision of PrEP among women and girls (UNAIDS, 2021). According to the Family Health International (FHI) 360 and Jhpiego (2021) study on the integration of PrEP and family planning, the National HIV Testing Services guidelines recommend integrating HIV testing into other health services, including family planning, and further advise that family planning services be offered to individuals seeking HIV testing. This demonstrates efforts to combine services at the policy level. Although family planning clinics are common points of entry for HIV prevention in Lesotho, service delivery remains inconsistent, and additional challenges, such as vertical

programme funding and the absence of integration guidelines for PrEP within family planning settings, persist (Nonyana et al., 2022).

2.3 A global account of current PrEP uptake among adolescent girls

UNAIDS (2024) reports that, although access to oral PrEP has expanded in regions such as Asia, the Caribbean, Africa, Latin America, and Europe, its use remains limited. The WHO's (2024) global PrEP report states that 94% of countries worldwide have integrated WHO guidelines on PrEP into their national policies. A gap immediately becomes noticeable between adopting guidelines which facilitate the expansion of PrEP and the actual uptake and use among people at risk of HIV infection. This discrepancy suggests that policy integration alone is insufficient to drive meaningful public health impact, pointing instead to persistent structural, social, and implementation barriers that limit real-world access and adherence. Consequently, the effectiveness of PrEP as an HIV prevention strategy depends not merely on its formal inclusion in national frameworks, but on how successfully these policies are translated into equitable, accessible, and context-responsive interventions for populations at highest risk. For instance, in 2023, nearly four million people globally received PrEP at least once, with the uptake increasing to 6.7 million users in 2024, but still potentially falling short of the 10 million UNAIDS target set for 2025 (UNAIDS, 2024; Chen-Charles et al., 2025). Global research suggests that the uptake and use of PrEP could be substantially higher if it were not for numerous factors discouraging use among individuals who are vulnerable to HIV, including PrEP-related stigma and low risk perception (Ogello et al., 2024; To & Lee, 2018; Lau, Hung, & Lee, 2020; Admassu et al., 2024; Kayesu et al., 2022).

In the USA, the risk of HIV remains high partly due to sub-optimal PrEP use among MSM, Black Americans, Latinos, people who inject drugs, adolescents aged 13 to 24, residents of the southern USA, and transgender women (Kamitani et al., 2020; Jackson, McCoy & White, 2024). Over a period of seven years, from 2016 to 2023, 1 450 296 prescriptions of PrEP were issued by nurses and physicians to 239 780 individuals aged 18 to 25 in the USA, the majority of whom were male (Hill, He & Chua, 2025). Further demonstrating the low PrEP uptake in the USA, of the 1.2 million people eligible for PrEP initiation in 2022, only 36% used PrEP (CDC, 2023; Sullivan et al., 2024). It is important to highlight the disparities in PrEP uptake among different groups in the USA. According to Griffith and Agwu (2023), racial disparities in prescribing PrEP exist among MSM, with Black and Hispanic MSM using PrEP at lower rates than white MSM. Similarly, among women, HIV risk and PrEP use vary by race, ethnicity,

and age, with younger Black women experiencing higher HIV risk while having limited awareness and lower uptake of PrEP (Griffith & Agwu, 2023).

Unlike the USA, which employs a pharmacy-based approach to optimise the use of PrEP among those who are vulnerable to HIV, Asian countries adopt a community-based approach (Lau et al., 2020). Although PrEP uptake across Asia remains below 10%, by 2023, 20 Asian countries had integrated PrEP into their national HIV guidelines, providing access to 204 000 people in 17 countries (UNAIDS, 2024). Similar to the USA, MSM and transgender women are disproportionately impacted by HIV in China, and they represent a large share of new infections relative to other groups, yet PrEP use remains limited (Sun et al., 2023; Liu et al., 2024). PrEP initiation in many countries in the Asia-Pacific region remains low, with only four countries reporting PrEP uptake of more than 10 000 people in 2022, namely Thailand, the Philippines, Vietnam, and Australia (Tieosapjaroen et al., 2025). In Europe, only 38 of 52 countries have adopted the WHO PrEP guidelines, with an estimated 344 596 people using PrEP in the 36 countries in the WHO European region (European Centre for Disease Prevention and Control, 2025).

In sub-Saharan Africa, PrEP uptake among adolescent girls and other key populations that are most vulnerable to HIV remains low, far below the UNAIDS target of 21.5 million by 2025 (Admassu et al., 2024; Murewanhema et al., 2022; Lekhutla & Taderera, 2025). In 2023, according to UNAIDS (2024), Eastern and Southern Africa had the highest number of PrEP users worldwide, with over two million out of a global total of 3.5 million. Chen-Charles et al. (2025) report that South Africa alone prescribed over 1.3 million PrEP doses in 2024, a relatively higher figure than that of other countries in the region. By the end of 2022, 32 258 people had used PrEP in Uganda, while an estimated 31 229 people in Lesotho received PrEP in 2023 (Uganda National Institute of Public Health, 2024; Government of Lesotho, NAC, 2024).

Worldwide, PrEP uptake remains significantly below the 21.2 million UNAIDS target for 2025, due to a combination of factors that discourage both the initiation and continued use of PrEP (Mukherjee et al., 2024). For example, a Namibian study among university students found that insufficient knowledge of PrEP benefits reduced their willingness to use it (Nakathingo, Ashipala & Iiyambo, 2021). Likewise, factors such as fear of stigma, misinformation, and low perceptions of risk impede the effectiveness of PrEP (Ogello et al., 2024; Lau et al., 2020;

Admassu et al., 2024; Kayesu et al., 2022; Lekhutla & Taderera, 2025). Section 2.4 discusses social barriers to the uptake of PrEP in more detail.

2.4 Identifying the factors that discourage the uptake of PrEP among adolescent girls

In the USA, factors that affect the uptake of PrEP can be viewed from different perspectives, including sex, sexual orientation, race, and location (Harawa, Tan & Leibowitz, 2022). Among Black MSM, significant barriers to PrEP include low levels of awareness, lack of medical aid, stigma associated with PrEP, concerns about mistrust in relationships, worries about side effects, and doubts regarding PrEP efficacy (Adeagbo et al., 2025). In relation to the racial disparities that exist in the USA, among the 363 148 people who accessed PrEP in 2022, 78% were white, 21% Hispanic, and 11% Black (Kamitani, Mizuno & Koenig, 2024). Many people who are eligible for PrEP but have not used it are Black MSM in the South, with perceived barriers such as poverty, lack of insurance, stigma, and limited access to skilled healthcare providers of PrEP (Kamitani et al., 2024). Among adolescents, confidentiality and inadvertent parental insurance disclosure are common perceived barriers, as insurance processes often reveal adolescents' use of contraceptives to their parents (Hall, 2022). These factors, as outlined in the Health Belief Model, hinder the adoption of recommended behaviours such as PrEP, a view supported by Clarke et al. (2000).

A quantitative study conducted in 15 Asian countries and territories identified stigma towards PrEP users and PrEP costs as significant barriers among MSM and transgender women (Tieosapjaroen et al., 2025). In Thailand, a 24-week pilot study among adolescents revealed that PrEP uptake and adherence were low due to the pill burden, concerns about privacy, and difficulty accessing health facilities (Rungmaitree et al., 2024). Additionally, Qin et al. (2024) polled 92 946 college students in China and found that despite the risk behaviours that render many of them eligible for PrEP, there was a lack of PrEP and SRH awareness, which potentially accounts for the low uptake of PrEP. In Europe, only 21 of 58 countries provide PrEP to all individuals irrespective of gender or sexual orientation, while others impose restrictive eligibility criteria that disproportionately disadvantage sex workers, migrants, and transgender individuals (European Centre for Disease Prevention and Control, 2025). Furthermore, a systematic review among European women found that low perception of risk, limited PrEP awareness, stigma, and fear of PrEP interfering with hormone therapy among transgender women were significant barriers (Fitzgerald et al., 2023).

Similarly, sub-Saharan Africa faces considerable stigma-related barriers to PrEP uptake, compounded by many other interrelated factors. A qualitative study in Malawi that explored factors that affect PrEP use among adolescents found that anticipated stigma was a major concern, with adolescents expressing fears of being labelled promiscuous or HIV positive (Nicholas et al., 2025). Another qualitative study conducted in Uganda, South Africa, and Zimbabwe identified barriers to PrEP uptake related to concerns about the effectiveness of PrEP, pill burden, stigma, and PrEP administration (Muhumuza et al., 2021). In Namibia, a qualitative study among 20 prospective users of PrEP identified uptake barriers associated with travelling distance to facilities, inadequate information and understanding of PrEP, and fear of judgement (Ashipala, 2024). In Lesotho, Chebet, McMahon, Tarumbiswa et al. (2023) found that PrEP uptake was affected by inadequate social support, low perceived susceptibility, disbelief about PrEP's effectiveness, perceived side effects, pill burden, and HIV-related stigma.

This section illustrates that many people worldwide experience various, albeit interrelated, factors that discourage and disrupt their uptake of PrEP, which contribute to low global levels. These challenges align with Health Belief Model constructs, including perceived susceptibility and severity, perceived barriers and benefits, as well as limited cues to action and self-efficacy. Section 2.4.1 discusses the social factors that influence the low uptake of PrEP as identified above. The section begins by discussing how stigma affects PrEP uptake and then proceeds to explore how misconceptions potentially influence the uptake of PrEP. Attitudes and beliefs shaping the lack of support for PrEP use are subsequently analysed using the Theory of Planned Behaviour framework, followed by an evaluation of PrEP availability and access.

2.4.1 The effect of PrEP-related stigma on the uptake of PrEP

In his book, titled *Stigma: Notes on the Management of Spoiled Identity*, Erving Goffman (1963) explores the origins of stigma, which date back to ancient Greece. The Greeks marked individuals considered criminals, traitors, slaves, or otherwise blemished by carving or burning symbols into their bodies. This was done to easily identify and avoid such individuals, especially in public spaces. Goffman (1963) defines stigma as a trait that significantly undermines an individual's credibility, which transforms them from a complete, normal person into someone perceived as flawed and devalued. However, critics such as Link and Phelan (2001) argue that Goffman's (1963) definition is too vague regarding what constitutes stigma.

They suggest that stigma involves a combination of labelling, stereotyping, separation, loss of status, discrimination, and the exercise of power (Link & Phelan, 2001).

On the one hand, Link and Phelan (2001) argue that, initially, people identify and label differences among humans; then, cultural norms associate those who are labelled unfavourably with negative stereotypes. Subsequently, labelled individuals are categorised to create an "us versus them" divide that leads to the loss of status and discrimination for the labelled person, which results in disproportionate outcomes. Finally, stigmatisation may occur. On the other hand, Andersen et al. (2022) challenge Link and Phelan's (2001) view by arguing that status loss, discrimination, and emotional reactions are redundant in defining stigma. Instead, they propose that stigma exists solely when there is labelling, negative stereotyping, linguistic separation, and a power imbalance (Andersen et al., 2022). Stigma can therefore be seen as a characteristic that differentiates individuals and underpins their social marginalisation and exclusion, as explained by Calabrese (2020).

According to Andersen et al. (2022), stigma is directed at groups rather than individuals, although it is the individuals in such groups who bear the consequences. It is worth noting that people who are stigmatised often experience mental health issues such as anxiety, depression, and suicidal ideation (O'Donnell & Foran, 2024). The American Psychiatric Association (2025) identifies three types of stigma: (1) public stigma, which involves negative attitudes from others, (2) self-stigma, which reflects negative attitudes, including internalised shame about one's own condition, and (3) structural stigma, which consists of policies by governments and private organisations that, intentionally or not, restrict opportunities for people with an illness. In addition, stigma can also be internalised, anticipated, and enacted (O'Donnell & Foran, 2024). Enacted stigma describes the direct discrimination an individual has faced; anticipated stigma refers to the expectation of being treated unfairly by others if they discover a stigmatised trait; and internalised stigma involves recognising negative stereotypes about one's group, accepting those beliefs, and turning them inward towards oneself (O'Donnell & Foran, 2024). For example, people living with HIV may internalise societal judgements and begin to have a poor image of themselves, which leads to self- or internalised stigma (Jackson, Eshiet et al., 2024). This internalised shame can potentially impede their willingness or ability to seek healthcare, disclose their HIV status, or access supportive communities (Mohammed et al., 2024).

In addition, the moralisation of HIV has deepened the existing stigma surrounding HIV and AIDS. Many Pentecostal groups demonise sex and HIV, viewing HIV as God's punishment for sinful sexual immorality (Kgatle, 2019). In many parts of the world, religious groups have evolved in their perception of HIV; shifting from silence and neglect to openly condemning it and labelling people living with HIV as "sexually immoral" individuals who needed to "repent" from their sins (Alio et al., 2019; Kgatle, 2019). This has frightened people and conditioned their thinking around HIV, linking it with immorality and sex. Such condemnation has significantly fuelled HIV-related stigma, which causes many to avoid testing, delay seeking treatment, and hide their status out of fear of judgement and rejection (Alio et al., 2019). Additionally, framing HIV/AIDS and sexuality within a spiritual context creates taboos around discussing these topics, which further perpetuates stigma (Madlala & Khanyile, 2023; Parsitau, 2009).

This HIV-related stigma has directly contributed to PrEP-related stigma. PrEP users in sub-Saharan Africa, particularly adolescent girls and young women, often fear being mistaken for being HIV positive when seen in queues with ART patients, as PrEP pills look similar to ARV pills, which many find difficult to distinguish (Velloza et al., 2020). This conflation leads PrEP users to anticipate stigmatisation from being labelled HIV positive, which results in secrecy, poor adherence, or discontinuation of treatment (Obeagu & Obeagu, 2024). The transfer of HIV and PrEP-related stigma is not coincidental, as negative social meanings attached to HIV, such as immorality, promiscuity, and irresponsibility, automatically transfer to anyone associated with HIV medication, even if it is for prevention (Velloza et al., 2020). Similarly, Chittamuru et al. (2020) report that the enacted HIV-related stigma experienced daily in communities fuels PrEP-related stigma, with people assuming that those taking PrEP are either HIV positive or promiscuous. It is therefore not surprising that a study among women in New York and Philadelphia reported that higher levels of PrEP-related stigma were significantly associated with lower intentions to initiate PrEP (Chittamuru et al., 2020). The perception that PrEP users are immoral or promiscuous highlights that PrEP-related stigma is an extension of HIV-related stigma, with the same effects, but causing distress to HIV-negative individuals instead. Ultimately, Yigit et al. (2024) contend that anticipated HIV-related stigma amplifies the adverse effects of PrEP-related stigma, which significantly reduces confidence in the ability to take up and adhere to PrEP regimens among those who need it.

Demonstrably, stigma hampers PrEP uptake, which remains relatively underused by sexually active adolescents despite its effectiveness and their vulnerability to HIV infection. Global

research indicates that PrEP-related stigma is especially rife in communities where PrEP is believed to have been developed for people who are at higher risk of HIV infection, such as female sex workers (FSWs) (Hussein & Ferguson, 2019; Velloza et al., 2020). Consequently, it fails to resonate with others and causes them to distance themselves from it. For example, a study among FSWs in South Africa found that marketing PrEP to high-risk groups increased stigma, with participants feeling that it reinforced harmful stereotypes about FSWs as HIV carriers (Makhakhe, Sliep & Meyer-Weitz, 2022). Furthermore, some married men avoid PrEP because their spouses perceive its use as a sign of infidelity or promiscuity (Olugo et al., 2025). Velloza et al. (2020) conducted a study on how HIV-related stigma affects PrEP disclosure and adherence among adolescents in Zimbabwe and South Africa. They discovered that many adolescents feared that partners, families, or peers would accuse them of infidelity or label them as prostitutes for using PrEP. In some cases, relationships ended after adolescents disclosed their PrEP use (Velloza et al., 2020). For this reason, adolescents in intimate relationships often encounter similar challenges, where they potentially avoid PrEP because they fear conflation with ARVs and are assumed to be HIV positive for using it (Rousseau et al., 2021; Muhumuza et al., 2021; Stoebenau et al., 2024). Calabrese (2020) reiterates that stigma diminishes interest, usage, and adherence, thus undermining PrEP's health benefits among those it could help.

In Lesotho, there is widespread confusion and misunderstanding among community members about the differences between PrEP and ART, which often leads to the erroneous belief that PrEP users are HIV positive (Geldsetzer et al., 2022). This misunderstanding heightens fears of social judgement, which discourages the open use of PrEP and leads to early discontinuation, particularly among adolescents (Obeagu & Obeagu, 2024; Geldsetzer et al., 2022). Additionally, healthcare providers in Lesotho note that poor messaging, such as unclear radio adverts depicting PrEP as a pill for those who are unable to use condoms consistently, inadvertently suggests sexual irresponsibility and stigmatises the use of PrEP (Geldsetzer et al., 2022). Moreover, some community members and healthcare providers view PrEP as promoting having multiple sexual partners or immoral behaviour among adolescents, which could potentially reduce providers' willingness to prescribe it (Geldsetzer et al., 2022). Evidently, stigma often stems from inadequate and incorrect information about a subject. The following section thus reviews literature on how misunderstandings about PrEP inform low uptake among adolescent girls.

2.4.2 Paucity of information on PrEP that results in low uptake among adolescent girls

Lekhutla and Taderera (2025) assert that sufficient knowledge of PrEP is essential for its effective uptake, as individuals who understand it are more inclined to use it. The digital age has significantly expanded access to vast amounts of information, which fundamentally transformed how the public consumes it compared to the past (Garett & Young, 2022). Consistent with the Health Belief Model, access to information may serve as a cue to action, potentially influencing behavioural change. Since information can significantly influence behaviour, health literacy is crucial for preventing and managing epidemics worldwide (Kalula et al., 2023). Zaller (1991) suggests that people's opinions, beliefs, attitudes, and values are formed through interactions with information; consequently, poor management of this information can mislead audiences and cause false narratives and perceptions. Garett and Young (2022) warn that misinformation is widespread and can negatively affect individual health behaviours and public health overall, especially because the rise of social media in recent years has created an environment that facilitates the spread of inaccurate, false, and malicious content due to low content regulation. In a world where everyone constructs their own narratives, information can easily be distorted. An example of the impact on public health is the development of antimicrobial resistance, a condition that arises from the incorrect use and premature discontinuation of medications, which enables microorganisms to evolve and become resistant to antimicrobial agents (WHO, 2023b).

Etowa et al. (2023) assert that PrEP-related misconceptions, defined as false beliefs that act as potential barriers to HIV and AIDS prevention and treatment, are common phenomena worldwide. A study that explored the views of adolescent girls and Black women on PrEP in the USA found that these groups generally believed that PrEP was primarily for FSWs and MSM, rather than for other demographic groups (Chandler et al., 2022; Crooks et al., 2023). Another study in North Carolina that examined knowledge of PrEP supported this perception, with women in low-income public housing communities reporting that they learned about PrEP from television commercials that emphasised men as the intended users, which reinforced the idea that it was not meant for women (Hill, Allison et al., 2025). Similarly, a study that assessed the readiness of PrEP provision in 23 Central and Eastern European countries found that MSM were considered the primary target group for PrEP (Gökengin, 2022; Kowalska et al., 2018). In sub-Saharan Africa, Rousseau et al. (2021) found that adolescent girls and young women in South Africa and Kenya initially perceived PrEP as a male-oriented intervention and only adopted it when it was integrated into broader SRH services, which highlights the importance

of integrated messaging. In contrast, a study among fishermen in Kenya found that some men believed that PrEP was intended only for women (Olugo et al., 2025). It is this uncertainty and misinformation about who should use PrEP that causes individuals who might benefit from it to avoid it.

Studies across sub-Saharan Africa and the USA report that many HIV-negative individuals frequently avoid PrEP because they do not want to be seen as promiscuous, assumed to have multiple sexual partners, or be considered unfaithful; they would rather distance themselves from its use (Rousseau et al., 2021; Muhumuza et al., 2021; Olugo et al., 2025). Mwakilasa et al. (2025) report that adolescents often fear being labelled as sex workers or immoral if their PrEP use becomes known. It is community misconceptions like these, which associate PrEP with promiscuity or HIV treatment, that discourage adolescents from initiating or continuing PrEP usage (Rousseau et al., 2021; Muhumuza et al., 2021). In addition, adolescents in sub-Saharan Africa usually distrust the safety of PrEP, frequently viewing side effects as an indication that the drug is unsafe or experimental, based on what they hear (Muhumuza et al., 2021; Mwakilasa et al., 2025). In South Africa and Kenya, as a testament to how prevalent misinformation can be, adolescents interpreted mild side effects as a confirmation of harm and temporarily stopped PrEP, often without consulting health providers (Rousseau et al., 2021).

Concerns about the effectiveness of PrEP and its potential side effects further inform the prevalent PrEP-related misconceptions. In the USA, adolescents are discouraged from taking PrEP every day because they fear long-term side effects of these pills, such as kidney and liver diseases (Dave, 2024). Additionally, social media posts about the adverse effects of PrEP often present a specific narrative that fuels scepticism, with some people believing that serious side effects are more common than official reports indicate (Grov et al., 2021). A study among young women in North Carolina revealed widespread worries about the safety of PrEP, especially when taken with other medications and during pregnancy, and concerns regarding long-term side effects that are unknown or unreported that leave room for speculation (Hill, Allison et al., 2025). Consequently, this suspicion of cover-ups fuels misconceptions and unverified conspiracy theories about PrEP, especially on unregulated social media platforms and podcasts. For example, due to these suspected cover-ups, adolescents in South Africa believe that a cure for HIV might already exist, since major pharmaceutical companies have the ability to develop HIV prevention medicines but choose to keep them hidden (Laher, Mahlangu & Sibiya, 2025). In addition, a study in Zambia that examined the factors that

influence PrEP uptake among key populations found that they feared rare, unconfirmed risks such as kidney failure, liver problems, blindness, and cancer (Stoebenau et al., 2024).

Another misconception that adolescents sometimes have is the belief that PrEP can also prevent other STIs and pregnancy (Nyamaizi et al., 2025; Geldsetzer et al., 2022). In parts of sub-Saharan Africa, some young women assume that PrEP protects against both HIV and pregnancy, which leads to reduced uptake of reliable contraceptive methods (Heffron et al., 2016; Geldsetzer et al., 2022; Seidman & Weber, 2016). Willie (2025) reports that such misunderstandings are exacerbated by the integration of PrEP messaging into reproductive health services, where its association with family planning unintentionally frames it as a dual protection tool. Rousseau et al. (2021) argue that although incorporating PrEP into SRH services increased access, it also led to some confusion regarding its preventive purposes, causing some to believe it does much more than just prevent HIV. This emphasises the importance of clear health messaging and the crucial role that healthcare providers play in explaining that PrEP specifically prevents HIV and does not offer protection against pregnancy or other STIs.

In addition, insufficient information on PrEP's protective capacity often leads to heightened levels of risky sexual behaviours. Since the introduction of PrEP, the use of condoms among high-risk populations has declined concurrently with increased STI incidences over the years (Von Schreeb et al., 2024). A qualitative study that investigated the link between PrEP and STIs among MSM found that PrEP was appreciated for offering peace of mind by alleviating concerns about contracting HIV and diminishing the need for using condoms (Williams et al., 2022). The apparent changes in behaviour are informed by the perceived reductions in HIV risk, which demonstrate how inadequate understanding of PrEP, particularly beliefs that it offers comprehensive protection, can influence decisions regarding the uptake of PrEP (Storholm et al., 2017). In contrast, studies among heterosexual serodiscordant couples, where counselling and risk reduction messages were intensive and consistent, report no evidence of risk compensation, which suggests that accurate information and ongoing education mitigate behavioural disinhibition (Holt & Murphy, 2017; Ortblad et al., 2020).

A study in Connecticut, USA, that explored views on PrEP discovered that many healthcare providers lack adequate training or confidence in offering sexual health counselling, which might contribute to ongoing misinformation (Willie, 2025). Mwakilasa et al. (2025) also found that inadequate provider training and poor privacy at facilities discouraged adolescents from

asking questions or receiving accurate information about all functions of PrEP, which leaves room for misconceptions to fester. It is therefore important for healthcare providers to be mindful of creating safe spaces that give adolescents an opportunity to seek accurate and adequate PrEP information, thus ensuring that misconceptions do not spread. In Lesotho, service providers unintentionally cause confusion as they try to help people understand PrEP. A study that assessed awareness of PrEP among providers and users in Lesotho found that PrEP users felt confused when a service provider told a serodiscordant couple that "these ARVs are hers, and those are yours" (Geldsetzer et al., 2022). These unclear instructions may potentially contribute to the prevalent misconceptions about PrEP. The next section discusses how the beliefs and attitudes that adolescents have towards PrEP influence its uptake.

2.4.3 How attitudes and beliefs among adolescents inform the uptake of PrEP

Attitudes and beliefs are essential for understanding behaviours such as PrEP uptake. While distinguishing between attitudes and beliefs can be challenging, beliefs are statements that can be factually verified (Eiser et al., 1997). Alternatively, Scheffer et al. (2022) define a belief as a notion or conviction that a person perceives to be true. For example, a person may hold a belief that they would not contract an HIV infection if they shower after sexual activity or that prayer alone can cure HIV/AIDS. Although a person may believe these to be true, they can be factually disproven. Conversely, Allport (1935) describes an attitude as a state of mental preparedness that is structured by experience, which informs how a person reacts to stimuli. In 1958, Rhine redefined an attitude as a concept that has an evaluative component and demonstrated that when forming an attitude, a person usually makes an assessment of some kind (Reid & Amanat Ali, 2020). More recently, Eagly and Chaiken (1993) combined these definitions and described an attitude as a mental tendency to assess an object with some level of approval or disapproval. Ajzen (1991) explains that favourable attitudes towards a behaviour increase the intention to adopt that behaviour.

Alongside PrEP-related stigma, beliefs and attitudes also inform decisions regarding PrEP uptake. In a study that assessed the awareness and adoption of PrEP among young MSM and women in the USA, Eaton et al. (2017) found a strong connection between a lack of interest in PrEP and the belief that it is for people with low inhibitions and reduced sexual morals. Another study that evaluated the implementation of PrEP in the USA found an entrenched belief that PrEP encourages promiscuity and unprotected sex and increases the number of sexual partners; it is thus perceived as morally unacceptable as an HIV prevention method (Calabrese, 2020).

Additionally, a qualitative study that assessed PrEP barriers in the USA revealed concerns among service providers that PrEP could increase risky sexual behaviours and lead to HIV drug resistance, thus resulting in provider reluctance to prescribe PrEP (Pleuhs et al., 2020). These beliefs and attitudes about PrEP contribute to a reluctance to seek it. In contrast, those who use PrEP tend to have a more positive attitude towards it. For example, a study that examined interest in PrEP among adolescents and young women in Europe found that their interest in PrEP was shaped by their perception of personal HIV risk, with those who believed they were at a higher risk showing increased interest in PrEP (Delabre et al., 2021). Similarly, a qualitative study on PrEP users and stakeholders in Lesotho found that the respondents viewed PrEP as offering security, protection, and a means to start a family even if one partner has been living with HIV for a long time (Geldsetzer et al., 2022). However, due to the negative belief that PrEP encourages sexual immorality, many users still report a lack of support from important people in their lives, which often results in discontinuation of use (Mwakilasa et al., 2025; Mudzingwa et al., 2024; Rousseau et al., 2021).

Furthermore, concerns about healthcare providers' attitudes may further hinder the use of PrEP. In sub-Saharan Africa, one study that aimed to establish a conceptual framework on PrEP-related stigma reported that healthcare providers viewed PrEP as less virtuous compared to condoms, which suggests that PrEP users were perceived as more reckless or promiscuous than those who use condoms (Hartmann et al., 2024). A similar study in Lesotho, involving healthcare providers and parents, found a belief that encouraging PrEP use by adolescents communicated a misleading message, which can potentially be interpreted as acknowledging and endorsing adolescents' sexual activity (Chebet, McMahon, Chase et al., 2023). Furthermore, a comparative study in Uganda, Zimbabwe, and South Africa found that unprofessional attitudes among healthcare providers discouraged patients from seeking PrEP counselling and initiating it, due to the belief that healthcare workers might disclose their use of PrEP to other community members who could recognise them (Muhumuza et al., 2021). The dismissive attitude of some healthcare professionals, who consider PrEP merely as ARV treatment, also undermines trust among potential users and diminishes their interest in using it (Makhakhe et al., 2022). Consequently, beliefs that PrEP encourages immoral sexual behaviour and healthcare providers' attitudes towards recommending PrEP to adolescents negatively affect the uptake of PrEP, especially among adolescents and other key populations that are susceptible to HIV. The following section assesses whether availability and access to PrEP play a role in the sub-optimal use of PrEP among adolescent girls.

2.4.4 Investigating access to PrEP among adolescent girls

In the USA, concerns about the costs of PrEP and clinic visit-related expenses likely deter many eligible individuals from starting PrEP (Hill, Allison et al., 2025). Many without private insurance avoid initiating PrEP due to worries about coverage, believing their insurance does not cover prescription bills, and fears of unintended disclosure, especially among adolescents using parental insurance (Felsher et al., 2018; Chandler et al., 2022; Smit & Masvawure, 2024). Similarly, in Southeast Asia, many at-risk populations that are eligible for PrEP show strong reluctance to pay out of pocket, indicating they would be willing to use PrEP if it were provided free of charge (To & Lee, 2018). Additionally, Murewanhema et al. (2022) emphasise that young women in sub-Saharan Africa encounter obstacles to PrEP access due to stigma and limited financial means to visit healthcare facilities. This creates a dual challenge, as both cost and fear of stigma hinder PrEP accessibility. Financial constraints related to travel and medication costs, healthcare consultations, and confidentiality in service provision pose significant challenges to PrEP uptake for many adolescents (Warzywoda et al., 2024; Jackson-Gibson et al., 2021).

In Lesotho, particularly in rural areas, the lack of infrastructure forces people to travel long distances to reach healthcare facilities (Mostafa et al., 2024). The distance alone poses several access challenges. Adolescents in rural areas who wish to use PrEP and other SRH services face the dilemma of inadvertently disclosing the source of their need for transport money to their parents, walking long distances alone and risking sexual violence and forced marriage, or avoiding clinic visits altogether during bad weather (Mostafa et al., 2024; Dick-Sagoe, Ernawaty & Odoom, 2025). Sometimes, potential users must travel long distances not because there are no facilities nearby, but because nearby facilities do not provide the required services. For example, Lesotho has an estimated 265 health facilities, of which around 38% are faith-based and founded on Christian values (UNICEF, World Bank & Government of Lesotho, 2017). These Christian facilities do not provide SRH services, including PrEP, due to their religious beliefs, which leaves potential users vulnerable (Government of Lesotho, Ministry of Health, 2021). For this reason, many adolescents benefit greatly from frequent outreach campaigns and school visits in their communities.

For many years, the USA has played a key role in supporting health initiatives and expanding access to vital HIV prevention services worldwide. The Lancet (2025) highlights that US funding for global HIV/AIDS development is essential as it contributed 74.5% of worldwide

efforts in 2023, mainly through the United States Agency for International Development (USAID). One example is the DREAMS programme, part of PEPFAR, which provides layered HIV prevention services to adolescent girls, young women, and their partners (Lavoie et al., 2025). Since its launch in 15 sub-Saharan African countries, DREAMS has been crucial in reducing HIV infection rates among young women and improving access to community-based violence prevention, HIV deterrence, and SRH services (US Department of State, 2020; Hartmann et al., 2024). Additionally, Van Heerden et al. (2020) observe that participants in DREAMS exhibited lower sexual risk behaviours and greater self-efficacy compared to non-participants, due to improved access to comprehensive HIV services.

However, access to donor-supported HIV prevention services was threatened after President Donald Trump's 2024 re-election. On 20 January 2025, his inauguration day, President Trump withdrew from the WHO, imposed a 90-day freeze on US foreign aid, and later issued stop-work orders on existing foreign assistance programmes while suspending new aid disbursements (Haug, Novoselova & Klingebiel, 2025; Dyer, 2025; Stolberg, 2025). As a result, USAID, previously labelled a "criminal" organisation by the Trump administration, was severely affected and rendered ineffective due to the foreign aid freeze executive orders, which raised concerns about potential global health repercussions (Gostin, Friedman & Wetter, 2025; Mildenberger, 2025). Martinez-Alvarez et al. (2025) highlight that these cuts will disproportionately impact the poorest and most vulnerable populations in LMICs, as many families may have to choose between skipping life-saving care or facing overwhelming medical costs and financial hardship. This situation is driven by reductions in key health services and an increase in out-of-pocket medical expenses. In Lesotho, as of March 2025, projects with a mandate to target key populations, provide PrEP, voluntary medical male circumcision, and a significant treatment, care, and health systems strengthening initiative remain terminated, which resulted in unimaginable service disruptions and gaps in the availability and access to PrEP (UNAIDS, 2025).

These developments highlight how the global expansion of PrEP, despite strong evidence of its effectiveness and broad policy adoption, remains highly susceptible to financial barriers, stigma, and geopolitical changes. Ultimately, the potential of PrEP as a key element of HIV prevention relies not only on scientific advances but also on ongoing political support and stable funding, which emphasises the main concern of this section: the increasing instability of global health financing and its direct impact on PrEP access. Nonetheless, a five-year Memorandum of Understanding between Lesotho and the USA was signed in December 2025,

which reinforced an 18-year partnership and ensured continued support for frontline health workers and critical health commodities (US Embassy Lesotho, 2025). This bilateral agreement will potentially improve access to PrEP and SRH services. To further enhance access to PrEP, Lesotho aims to become one of the first countries to roll out lenacapavir in February 2026, an injectable PrEP regimen that is received only twice a year (Lesotho News Agency, 2025). The following section discusses the theoretical framework of the study.

2.5 Theoretical framework

This study was grounded in two key behavioural theories: the HBM and the TPB. The integration of these frameworks offered a robust perspective for analysing the social factors that influence adolescent girls' decisions regarding PrEP uptake within the context of donor-funded family planning services in Berea, Lesotho. The HBM explains how perceptions of risk, benefits, and barriers affect health decisions (Becker, 1974; Rosenstock, 1974). Meanwhile, the TPB (Ajzen, 1991) extends this by considering how attitudes, subjective norms, and perceived behavioural control influence intentions and behaviour. These frameworks collectively enable a multidimensional examination of how personal beliefs, social expectations, and structural factors intersect to shape HIV prevention behaviours among adolescent girls. The discussion begins by examining the HBM and then proceeds to apply the TPB to the low uptake of PrEP among adolescent girls who use family planning services.

2.5.1 The health belief model (HBM)

The HBM was developed to explain health behaviour (Rosenstock, 1974). According to Rosenstock, Strecher and Becker (1988), the HBM posits that health-related behaviour depends on three factors: (1) sufficient motivation to consider health issues seriously, (2) belief in personal vulnerability to a critical health condition, and (3) belief that adopting a specific health recommendation would help to reduce the risk of that condition. Pierre (2021) emphasises that the HBM aims to understand the link between a person's beliefs or perceptions and their health actions. He further states that the model is frequently used to explore why people engage in or avoid preventive health measures and has been notably applied to understand the uptake of HIV prevention strategies such as HIV testing and condom use (Pierre, 2021). The HBM suggests that the likelihood of adopting a specific health behaviour depends on perceived susceptibility to and severity of illness, perceived benefits and barriers to the behaviour, cues to action, and self-efficacy (Hossain et al., 2021). The HBM can therefore help to determine

whether adolescents who receive PrEP messages become aware of their vulnerability to HIV and the consequences of acquiring it. It also assesses whether they recognise the benefits of taking PrEP, identify perceived barriers, and feel confident in their ability to use PrEP as advised.

The HBM posits that individuals' decisions to engage in health-promoting behaviour are influenced by six constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and cues to action (Alyafei & Easton-Carr, 2024). While the HBM is founded on these six core constructs, Winkelman (2021) notes that perceived susceptibility, perceived benefits, and perceived barriers are most pertinent to PrEP. These are elaborated on below.

In South Africa, a study that applied the HBM and TPB to assess intentions to take up PrEP among parents and adolescents found that, among adults, cues to action and perceived barriers related to access and cost influenced PrEP intentions (Nkambule, 2025). Among adolescents, higher intentions were associated with perceived benefits and subjective norms, whereas perceived severity had a slight negative effect (Nkambule, 2025). Regarding adolescent girls in Berea in this study, the HBM offered an analytical tool to understand whether they perceived themselves to be at risk of HIV infection, how seriously they considered the consequences of infection, and what barriers prevented them from using protection. The following section discusses three constructs of the HBM, namely perceived susceptibility and severity (or perceived threat), perceived benefits, and perceived barriers.

2.5.1.1 Perceived susceptibility and severity (perceived threat)

Perceived susceptibility concerns whether people believe they are personally at risk of contracting HIV (Janz & Becker, 1984). Adolescent girls in Berea might not see themselves as vulnerable, especially if they are in relationships where they trust their partners, or if HIV is linked to "other" groups rather than themselves. The perception that others are at greater risk is what Clarke et al. (2000) refer to as excessive optimism, which occurs when individuals believe their situation is better than that of others in similar circumstances. Rosenstock (1974) stresses that low perceived susceptibility often results in not engaging with preventive measures, even when services are available. As a result, adolescent girls with this optimistic bias may think they are at a lower risk of acquiring HIV than their peers and may choose not to use PrEP.

In the perceived severity or seriousness construct, individuals must first recognise and consider the potential consequences of contracting the disease (Winkelman, 2021). Specifically, they must evaluate the social implications and dangers of HIV/AIDS, the severity of its symptoms, and the chances of recovery or death. Subsequently, in the context of Berea, Lesotho, adolescent girls may reflect on their vulnerability, considering their engagement in risky sexual behaviours, having multiple partners, and other factors that increase their risk of HIV/AIDS. Perceptions of severity may also be shaped by the long-standing visibility of HIV-related deaths but may also be moderated by the normalisation of ARV treatment, which might reduce fear of infection. Champion and Skinner (2008) refer to the combined perceptions of severity and susceptibility as a perceived threat, which is critical for motivating PrEP uptake. Based on their assessment of vulnerability, individuals are motivated to weigh the benefits of adopting the recommended behaviour, namely PrEP.

2.5.1.2 Perceived benefits

Perceived benefits refer to the belief that PrEP will lower the risk of HIV infection, based on factual information about PrEP, personal impressions of its effectiveness, and perceptions of what significant others expect from them (Clarke et al., 2000). Rosenstock (1974) argues that individuals are more likely to adopt a behaviour if they believe it offers tangible health advantages. Similarly, Champion and Skinner (2008) add that even if someone thinks they are at considerable risk of HIV infection, their willingness to adopt a recommended behaviour depends on their beliefs about the benefits of various actions that could reduce that risk. Before adopting a particular behaviour, such as initiating PrEP, an individual might also consider other strategies first, such as practising safer sex or limiting sexual partners, which could lower their vulnerability to contracting HIV. Ultimately, Rosenstock (1974) suggests that a treatment or strategy is deemed beneficial if it appears to personally decrease the likelihood or severity of illness. This assessment depends more on beliefs about the availability and efficacy of options than on the objective facts of their actual effectiveness. Among adolescent girls in Berea, benefits may include protection against HIV in relationships where condom negotiation is difficult, thus increasing their sense of control over their health. However, these benefits may be undermined if PrEP is conflated with ARVs for people living with HIV, thus leading to confusion about its preventive function.

2.5.1.3 Perceived barriers

A person's strong desire to change their behaviour can be weakened if they feel discouraged or overwhelmed by challenges, obstacles, or barriers that seem to hinder their progress (Van Dyk et al., 2017). According to Clarke et al. (2000), perceived barriers are factors that prevent the adoption of recommended behaviours, including cost, pain, inconvenience, distance, time constraints, forgetfulness, embarrassment, and loss of enjoyment. Consequently, someone may believe that a particular action could effectively reduce their disease risk but simultaneously view that same action as inconvenient, costly, unpleasant, painful, or distressing (Rosenstock, 1974). Janz and Becker (1984) therefore argue that the potential disadvantages of a health behaviour can discourage individuals from following through, as people often weigh the benefits against concerns about possible severe side effects. Regarding PrEP adoption, despite its proven effectiveness in preventing HIV, factors such as stigma associated with PrEP, lack of support from key individuals, confusion with ARVs, and fears of side effects may deter people from using it. Becker (1974) warns that perceived barriers often outweigh perceived benefits in shaping behaviour. In Berea, donor-funded family planning services may unintentionally exacerbate barriers if adolescent girls feel judged or exposed when seeking PrEP in clinics designed for reproductive health.

2.5.2 The theory of planned behaviour (TPB)

The TPB, developed by Ajzen (1991), extends the earlier theory of reasoned action (Ajzen & Fishbein, 1980). Ajzen (1991) argues that behaviour is best predicted by behavioural intention, which in turn is influenced by attitudes towards the behaviour, subjective norms, and perceived control. Unlike the HBM, which emphasises risk perception, the TPB foregrounds intentionality and the social environment as key determinants of behaviour. According to Tornikoski and Maalaoui (2019), the TPB explains what influences human actions and predicts future behaviour by assuming that individuals think critically about their choices. This model proposes that humans are inherently rational and carefully evaluate information to decide how they want to act (Van Dyk et al., 2017). It builds on the theory of reasoned action, which suggests that behaviour is driven by the intention to act. The latter depends on personal control, where stronger intentions make action more likely (Ajzen, 1991). The theory also notes that perceived behavioural control moderates this relationship, which means the more control a person perceives to have, the more likely they are to act on their intentions (Ajzen, 1991; Tornikoski & Maalaoui, 2019). Conversely, while attitudes relate to perceptions of a behaviour,

subjective norms concern the perceived social pressure from influential others to perform or avoid the behaviour, and perceived behavioural control is a person's belief in how easy or difficult it is to perform the behaviour (Tornikoski & Maalaoui, 2019). Using this theory alongside the HBM helped to explore adolescents' intentions and their perceived ability to take up PrEP, and how the opinions of significant others impacted their decisions.

According to a study that applied the TPB framework to evaluate the use of PrEP among populations that are susceptible to HIV in sub-Saharan Africa, subjective norms were found to have the greatest influence on PrEP uptake in countries such as Uganda and Kenya (Dzenu et al., 2025). For adolescent girls in Berea, Lesotho, the TPB provides insight into how their intentions to use PrEP are shaped not only by personal beliefs but also by social expectations and their sense of agency. The following section discusses three TPB constructs: attitude towards a behaviour, subjective norms, and perceived behavioural control.

2.5.2.1 Attitude towards a behaviour

Attitudes are positive or negative evaluations that an individual holds towards someone or something, such as PrEP (Ajzen, 1991). Ramos (2024) describes attitude as a learned tendency to respond consistently, either positively or negatively, to a specific object or event, or as an overall judgement of a particular behaviour. It encompasses an individual's general evaluation, which is influenced by their thoughts, beliefs, and emotions. In health behaviour, attitude indicates how favourably or unfavourably a person perceives engaging in a specific action.

Attitudes towards PrEP relate to personal judgements about its usefulness, necessity, burden, or risk. These perceptions affect whether individuals are willing to start or continue using PrEP. According to Worthington (2021) and Ajzen (1991), a more positive attitude towards a behaviour is linked to stronger intentions to act. Consequently, when adolescent girls view PrEP favourably, they are more inclined to consider and adopt it as an effective tool for HIV prevention. Adolescent girls may perceive PrEP as empowering because it provides self-directed protection, or as burdensome if it is associated with stigma, pill burden, or the perception that only "promiscuous" girls use it. These evaluations are critical in shaping their decisions regarding uptake.

2.5.2.2 Subjective norms

Subjective norms refer to perceived social pressures to perform or avoid a behaviour (Ajzen, 1991). According to Worthington (2021), subjective norms are social influences on an individual's intention to act, particularly the perceived expectations of key others. These norms stem from a person's beliefs about whether important individuals or groups, such as family, partners, peers, or healthcare providers, approve or disapprove of a certain behaviour. Ajzen (1991) also describes subjective norms as perceived social pressures that impact decision making about actions.

In the context of PrEP uptake among adolescents in Berea, subjective norms are particularly important. If adolescent girls believe that their esteemed friends support PrEP use, they are more likely to consider it. Conversely, if salient others disapprove, they may be discouraged from using PrEP, even if they recognise its benefits themselves. Multiple studies support this, which shows that social approval or disapproval greatly impacts whether someone starts using PrEP (Rugira, Biracyaza & Umubyeyi, 2023; Chebet, McMahon, Tarumbiswa et al., 2023; Rousseau et al., 2021; Muhumuza et al., 2021). In essence, subjective norms represent both the influence of others and an individual's internal desire to conform to or seek approval from those they respect (Van Dyk et al., 2017).

2.5.2.3 Perceived behavioural control

Perceived behavioural control pertains to an individual's belief in their ability to successfully perform a specific action (Ajzen, 1991). Van Dyk et al. (2017) describe it as how easy or difficult a person perceives it will be to carry out the behaviour, while Worthington (2021) links it closely to self-efficacy, which is the confidence in one's capacity to act. Research shows that people who feel more in control of their actions are more likely to start and stick with new behaviours, including health-related ones, even when facing obstacles (Van Dyk et al., 2017; Gardner et al., 2023). For PrEP use in Berea, adolescents who believe they can manage PrEP, despite challenges such as daily pills, side effects, or stigma, are more likely to initiate and continue using it. Conversely, if they doubt their ability to adhere to daily PrEP or fear societal judgement, their sense of control drops, thereby reducing the likelihood of PrEP use. Building confidence and addressing perceived barriers are therefore essential for increasing PrEP adoption.

2.6 Combination of the HBM and TPB

Although both models provide valuable insights on their own, their combination offers a more comprehensive framework. The HBM and TPB are both based on the idea that personal perceptions and intentions influence health actions (Tarkang & Zotor, 2015). According to the HBM, people are more likely to engage in preventive health behaviours if they see themselves as at risk of a health issue, believe the problem has serious consequences, recognise that specific actions can lower their risk or severity, and perceive that the benefits of acting outweigh any costs or barriers (Champion & Skinner, 2008). The model also includes factors such as cues to action and self-efficacy, which affect an individual's readiness to make changes.

The HBM provides a structured framework for evaluating an individual's motivation to modify health behaviours (Alyafei & Easton-Carr, 2024). It considers their perceived risk of illness, the gravity of potential consequences, the advantages and practicality of recommended actions, and the barriers they might face in adopting new behaviours (Rosenstock, 1974; Champion & Skinner, 2008; Clarke et al., 2000). However, even when these factors are present, a person may still not change if they feel at risk, perceive severe outcomes, and recognise the benefits. This highlights a limitation of the HBM: it may not fully account for why some individuals remain unmotivated despite being aware of and rationalising their actions.

The TPB offers a complementary perspective by proposing that behavioural intention is shaped by three main factors: attitude towards the behaviour, subjective norms (social pressure), and perceived behavioural control (similar to self-efficacy) (Sniehotta, Presseau & Araújo-Soares, 2014). When the HBM fails to motivate behavioural change, the TPB emphasises that an individual's willingness and perceived ability to act, driven by social influences and internal motivation, are crucial in predicting actual behaviour. For instance, a young woman might be aware of her HIV risk and the seriousness of infection and understand the benefits of PrEP, yet still decide not to use it. This choice could be due to personal doubts, distrust in PrEP, a preference for other prevention methods such as consistent condom use, or social norms that stigmatise PrEP users. In such cases, the constructs of the TPB, especially attitudes, subjective norms, and perceived behavioural control, are essential for understanding and bridging the gap between knowledge and action.

Combining the HBM and TPB creates a more comprehensive framework for understanding the social factors that influence low PrEP adoption and for designing effective health promotion

programmes. Interventions based on both models can address a wider variety of behavioural characteristics. For example, programmes can inform individuals about their risk (HBM), address negative perceptions of PrEP (TPB attitude), involve supportive peers or partners (TPB subjective norms), and enhance users' confidence in managing PrEP despite potential challenges (TPB perceived behavioural control). Overall, integrating these models enables a deeper understanding of health behaviour, especially in complex decisions such as PrEP uptake among adolescent girls, and provides a solid foundation for targeted, personalised interventions.

In the context of PrEP uptake among adolescent girls in Berea, combining these models allowed for analysis of how donor-funded interventions, as external cues, interact with adolescents' personal beliefs and the social pressures they face. For example, an adolescent girl may perceive herself at risk of HIV (HBM), but if her partner disapproves of PrEP (TPB), or if she lacks confidence in her ability to adhere to it (HBM/TPB overlap), she may not take it. This integrated model is therefore essential for identifying multi-level interventions: risk communication (HBM), peer engagement (TPB), and empowerment strategies to improve self-efficacy (HBM/TPB).

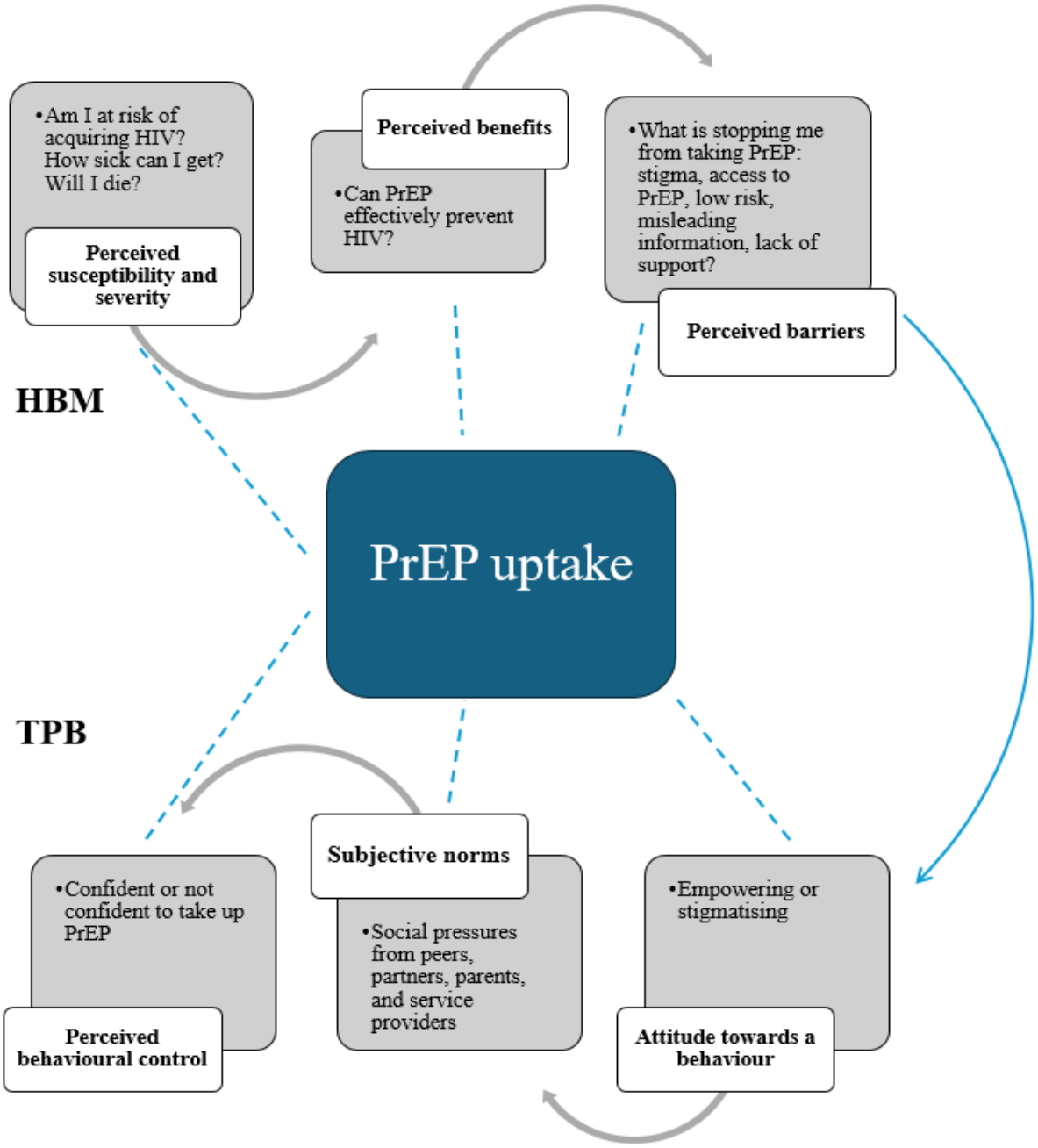

Figure 2.1: Theoretical framework integrating the HBM and TPB into exploring the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho

Figure 2.1 presents the integration of two behavioural theories, the HBM and TPB, to formulate an understanding of the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho. The solid grey arrows signify that an evaluation of one idea may lead to an assessment of another before a decision is made to either take up or decline PrEP. The blue dotted lines depict that an adolescent could decide to take up PrEP at any point in their risk assessment for HIV infection. The solid blue arcing arrow

highlights an essential link between the two theoretical frameworks, which indicates when an adolescent girl may need to make further assessments of attitudinal and social influences from salient others that have a bearing on their health decisions. This means that if an adolescent is convinced or unsure about their personal health decision made solely based on a personal risk assessment, they may also want to consider how those close to them feel about PrEP and base their decision on that.

Starting with the HBM, an adolescent girl may want to determine whether she is indeed at any real risk of acquiring HIV. She would want to reflect on factors that heighten her vulnerability to HIV and situate herself in that context. She will assess her susceptibility to HIV and how much she would suffer if she acquired it. If she identifies herself as vulnerable to HIV infection, she may take up PrEP immediately, without further assessment; however, if she is not convinced, she will make further assessments. She would want to see if she can achieve the same level of protection against HIV using other methods and compare the benefits of adopting PrEP with those of other methods. At this point, adolescent girls may decline PrEP and try other methods, decide to initiate PrEP, or make further assessments. In Step 3, perceived barriers, they may want to assess which factors potentially hinder them from taking up PrEP, such as PrEP-related stigma and access to PrEP. At this stage, an adolescent girl may initiate PrEP, decline it, or want to see what her friends think about it. This is where the HBM and the TPB overlap.

The TPB asserts that an adolescent girl will evaluate her attitude towards PrEP, considering whether taking it will make her feel empowered and protected or whether she fears being stigmatised for using it. She may decide to take PrEP if she has a positive attitude towards it, decline it, or consider what others around her think of it. Regarding subjective norms, if an adolescent girl's reference group believes PrEP is harmful, she is likely to align with that group and not take PrEP. However, if the reference group views it as helpful, she is likely to use it as well. Nevertheless, some may want to be sure that they will be able to adhere to PrEP, withstand the side effects, and handle the pill burden or any stigmatising opinions they may encounter. If this self-efficacy assessment is positive, they are very likely to take up PrEP; but if it is low or negative, they may not end up taking PrEP and may have to re-evaluate their susceptibility to HIV.

2.7 Conclusion

The literature reveals that many adolescent girls across the world face a dual problem of unintended pregnancies and HIV infections. The unmet need to prevent both leads them to drop out of school and seek early employment opportunities that do not offer adequate remuneration due to low educational levels. They often face stigma and have limited access to healthcare services as a result. However, research suggests that despite global efforts to meet the pregnancy and HIV prevention needs of adolescents, the uptake of recommended interventions such as contraceptives and PrEP remains low. The literature supports that this is because adolescents still fear being judged, being mistaken for being HIV positive, taking PrEP, – which is commonly conflated with ARVs – and being labelled as sexually immoral, and do not perceive themselves as being in any real danger of acquiring HIV, despite information dissemination efforts.

Globally, literature demonstrates that the integration of HIV prevention into SRH services is seen as critical in reducing HIV-related stigma, travel costs, and waiting times. Integrating PrEP into family planning services also has the potential to improve HIV prevention outcomes among adolescent girls, as they are already accessing SRH services. Potentially, PrEP will be offered to adolescent girls in youth-friendly family planning clinics during family planning service follow-up and consultation visits. These insights set the stage for examining how theoretical frameworks such as the HBM and TPB can deepen the understanding of social factors that contribute to the low uptake of PrEP among adolescent girls who use family planning services in Berea, Maseru.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodological framework employed to explore the social factors that influence the low uptake of PrEP among adolescent girls who use family planning services from donor-funded projects in Berea, Lesotho. This study employed a qualitative research approach, specifically grounded in an interpretive phenomenological paradigm, to explore the lived experiences of adolescents and the subjective meanings they attribute to their interactions with PrEP services. The rationale for adopting an interpretive approach is discussed, along with the appropriateness of a qualitative research design for capturing complex behaviours and social contexts.

Purposive sampling was utilised to recruit participants who could provide the required information, guided by clearly defined inclusion and exclusion criteria. This chapter further outlines the data-collection and analysis procedures, which involved semi-structured, one-on-one interviews conducted both telephonically and face to face, chosen for their ethical and logistical suitability. Braun and Clarke's (2006) six-stage thematic analysis framework, which enables the systematic identification of patterns and emergent themes, guided the data analysis. Ethical considerations, including informed consent, confidentiality, and participant well-being, are comprehensively addressed in this chapter. Finally, strategies to ensure reliability, trustworthiness, and methodological rigour are also discussed to highlight the study's ethical foundation and its capacity to generate meaningful insights into the barriers to PrEP uptake among adolescent girls.

3.2 Interpretive phenomenological approach

Phenomenology is concerned with understanding how individuals experience and make sense of the world around them from their own first-person perspective and examines how things are viewed in lived experience and the meanings individuals attach to them (Smith & Zalta, 2018). Flood (2010) argues that subjective human experience reveals aspects of reality that cannot be captured through purely quantitative or positivist approaches that are predicated upon objective reality alone. From this perspective, individuals' experiences cannot be separated from the social, cultural, and relational environments in which they live. As a result, this study employed

an interpretive phenomenological approach to go beyond merely describing the PrEP experiences of adolescent girls who use family planning services in Berea, and to analyse how they interpret, navigate, and construct meaning around those experiences (Alase, 2017). This approach allowed the analysis to move beyond surface-level narratives and uncover deeper understandings embedded in the adolescents' experiences with PrEP (Alharahsheh & Pius, 2020). Interpretive phenomenology recognises that knowledge and understanding are co-constructed, wherein individuals make sense of their experiences, and researchers attempt to make sense of these meanings (Smith & Osborn, 2015). Although phenomenology offers limited scope for generalising findings, as it is grounded in individual lived experiences, it was preferred over alternative approaches due to its capacity to generate in-depth, richly detailed accounts of participants' experiences and the meanings they attribute to them.

For this study, interpretive phenomenology was a useful method because the uptake of PrEP among adolescent girls is affected not only by their knowledge of PrEP but also by social factors such as PrEP-related stigma, low perception of risk, lack of support, community expectations, trust in partners, and fear of judgement. This approach enabled an exploration of these influences, which often operate beneath the surface of what adolescents would initially disclose. Interpretive phenomenology allowed the researcher to uncover these deeper, often unspoken interpretations by exploring how adolescent girls understand their risk of HIV and the social influences in their communities (Alharahsheh & Pius, 2020). As Thanh and Thanh (2015) note, interpretivist phenomenology emphasises the importance of the beliefs, values, and worldviews held by both participants and researchers in constructing reality. This aligns with the aim of this study to explore social meanings surrounding PrEP; meanings that cannot be accessed through quantitative measures alone. Consequently, this approach supported a richer, more nuanced understanding of the lived experiences with the social factors that inform the low uptake of PrEP among adolescent girls in Berea, Lesotho.

3.3 Research design

This study employed a qualitative research design to investigate why PrEP is underutilised among adolescent girls. This method focused on understanding their attitudes, behaviours, beliefs, interactions, and experiences (Pathak, Jena & Kalra, 2013). Aspers and Corte (2021) describe qualitative research methodology as a step-by-step process that helps the scientific community to understand reality by revealing new and significant distinctions through a closer examination of the topic under study. Similarly, Al-Ababneh (2020) argues that qualitative

research enhances understanding of the reasons behind social phenomena and human behaviour. A qualitative design was well suited to this study because it allowed for an in-depth exploration of the social factors that inform decisions around the uptake of PrEP among adolescent girls. According to Creswell (2018), this design focuses on how participants interpret and give meaning to their experiences, which ultimately determines whether adolescent girls will use or decline PrEP. This research design therefore allowed me to capture the perceptions and emotions that adolescent girls associate with using PrEP, such as fear of being judged and labelled as immoral, which are often overlooked in survey-based or quantitative studies (Babbie, 2021; Creswell & Poth, 2017). Moreover, qualitative methods, such as semi-structured interviews, offered the flexibility to delve deeper into emerging issues during data collection, thus ensuring that the voices of adolescents guided the research process (Creswell & Creswell, 2018). As a result, the inherent flexibility of the qualitative research design enhanced the authenticity and relevance of the findings, which enabled the study to reveal the lived realities surrounding PrEP uptake among this demographic.

3.4 Sampling method and selection of participants

Islam, Khan and Baikady (2022) define a sample as a collection of participants or respondents chosen from and representative of a larger population. Dahal et al. (2024) assert that when conducting phenomenological studies, it is crucial to carefully select the research problem and participants and to develop well-defined research questions to capture the essence of participants' experiences and derive meaningful insights. Ahmed (2025) adds that in phenomenological studies, determining the sample size is less about meeting a specific number and more about ensuring that data collection provides deep and meaningful insights. For phenomenological studies, Creswell and Poth (2016) recommend a range of five to 25 participants to participate in a study until data saturation is achieved.

A non-probability purposive sampling technique was employed in this study, with an initial target of 10 participants. This was an acceptable number since it aligned with qualitative research norms for phenomenological studies, which typically involve small, information-rich samples. Guest, Bunce and Johnson (2006) observed that thematic saturation is often achieved within the first 12 interviews, with most major themes emerging after six. However, recent literature is less focused on the number of participants and instead advises that researchers may need to add participants until no new information is revealed (Sarfo et al., 2021; Dahal et al., 2024). Guided by the principle of data saturation, which is defined as the point at which no

new themes or insights emerge, 12 participants were interviewed (Hossain, Alam & Ali, 2024). While the intention was to interview 10 participants, data saturation was not reached at this point. I therefore identified two additional participants, which brought the total sample size to 12 adolescent girls between the ages of 18 and 19. This process provided the depth and breadth necessary to capture the diversity and complexity of experiences of adolescent girls with PrEP uptake. As Babbie (2016) notes, participant selection in non-probability sampling is devoid of chance or random processes. Consequently, a deliberate purposive sampling technique was employed, as it enabled the selection of adolescent girls with first-hand experience of the low uptake of PrEP under study. Employing a purposive sampling method was essential because it provided an opportunity to gather nuanced, context-specific insights that could only be provided by adolescent girls who had personally navigated the challenges surrounding PrEP uptake.

The initial participant recruitment plan was that a representative from CoHiP SEC would help distribute the information sheets to potential participants, inform me of those interested in participating, and I would then follow up with them to provide further clarification and schedule interview appointments. This plan was not executed because the gentleman from CoHiP SEC was unavailable to begin the process by handing out the information sheets due to other work commitments. Consequently, management provided me with office space at CoHiP SEC, where I could meet in person with potential participants and provide them with additional study information. These adolescent girls received an information sheet from a nurse when they visited for family planning services and were referred to me for more details if they expressed interest in participating. This face-to-face interaction allowed me to build rapport with potential participants, which might have been more challenging over the telephone. Rapport with potential participants was established by using simple, everyday language to explain the details of the study. I was careful not to position myself as more knowledgeable than the participants; instead, I reassured them that their experiences and perspectives were central to the research. Additionally, the telephone number from which the interview calls would be made was shared with the participants in advance to promote transparency and comfort. The following criteria were used to include potential participants. Those who did not meet these criteria were excluded from participating in the study.

- Adolescent girls aged 18 and 19;
- Berea residents; and

- CoHiP SEC family planning clients.

Potential participants were excluded if they were:

- adolescent girls below 18 years or older than 19 years;
- not residents of Berea; or
- family planning clients from other health facilities.

In addition, recruiting participants from within the CoHiP SEC offices addressed concerns of safety when dealing with young girls and discussing issues related to sex. Due to the sensitivity of PrEP and family planning discussions, which centre on women's sexuality, it was difficult to recruit participants by myself; I thus relied on the CoHiP SEC nurses to distribute the information sheets to prospective participants. Without misrepresenting my identity, being seen by prospective participants in the CoHiP SEC offices improved their confidence in the legitimacy of the research study. When they were directed to me, I introduced myself as a master's student at the University of South Africa (UNISA) researching the social factors that influence the low uptake of PrEP among adolescent girls who use family planning services in Berea, and I provided clarity on the areas in which they expressed interest. Nine adolescent girls agreed to be interviewed immediately, and the other three, who were pressed for time, were happy to arrange for telephone interviews at a more convenient time.

The selection of participants took into account the possibility that some adolescent girls might not have disclosed their use of family planning services to their caregivers. Others might not have been prepared for their peers to learn about their participation in an HIV-related study due to fears of judgement, stigma, and social exclusion by friends and family. Consequently, being present at service delivery points when adolescents sought care minimised the risk of inadvertent disclosure to significant others or to individuals who were unaware of the services they were accessing. Furthermore, pseudonyms were assigned to all the participants to protect their identities and are used throughout the dissertation.

All the participants were still living at home with their parents in the district of Berea. Eight of them lived in nearby villages in the town of Teyateyaneng, the capital of Berea, and four were from rural villages in Berea. Some were within walking distance of the CoHiP SEC clinic in Berea, while the other four relied on public transport to reach CoHiP SEC. Two participants had a secondary school education, eight had completed Grade 11, and two had a post-high school entry-level certificate. Table 3.1 provides a profile of the participants that indicates their

assigned pseudonyms, age, duration of using family planning services, and whether they had ever used PrEP.

Table 3.1: Profile of the participants

No.	Pseudonym	Age	Duration of family planning use	Ever used PrEP
1	Mosa	19	12 months +	No
2	Kholu	19	First month	No
3	Praise	19	First month, reinitiation	Yes, discontinued
4	Palesa	18	Second month	No
5	Mapule	19	3 months, reinitiation	Yes, discontinued
6	Lethabo	19	12 months	Yes, discontinued
7	Kabelo	19	First month	Yes, current user
8	Lerato	19	First month	Yes, discontinued
9	Reena	19	First month	Yes, discontinued
10	Grace	18	12 months	No
11	Dudu	18	24 months	No
12	Reteng	19	36 months	Yes, discontinued

Consistent with the study's criteria, all the participants were adolescent girls aged 18 or 19. They were current family planning service users at the CoHiP SEC clinic in Teyateyaneng, Berea. The goal was not to compare data between 18- and 19-year-olds but to gather extensive information from girls of varying ages to better understand family planning and PrEP experiences. Some girls accessed family planning for the first time, while others had been using it for over 12 months. Additionally, six girls had never taken PrEP, five had used it but stopped, and only one was actively using it. These differences between never-users and users enriched the study by providing insights from those with direct PrEP experience and those without. It was also interesting to hear from adolescent girls who had used family planning for a longer time but were not interested in using PrEP, to find out what informed their convictions.

3.5 Data-collection methods: Semi-structured interviews

The interpretive phenomenological research design employed by this study offered an invaluable opportunity to collect first-hand, nuanced data from adolescent girls who used family planning services in Berea through semi-structured interviews. Semi-structured interviews were conducted with 12 participants, following an interview guide (see Appendices H and I) to anchor the discussions. Magaldi and Berler (2020) argue that semi-structured interviews are exploratory in nature, grounded in a core set of questions, yet flexible enough to follow the directions that participants themselves prioritise. This method was suitable for this study because it not only provided the participants with the freedom to voice their experiences

and perspectives on PrEP but also allowed for probing. The interview guide, designed around open-ended questions, ensured that the conversations remained focused while still allowing the participants to shape the flow of the dialogue. It contained questions such as “Talk to me about some of the benefits of taking PrEP that you know”, and “Tell me about some of your experiences with PrEP”. The interviews were conducted only after obtaining ethical clearance.

Many Basotho primarily speak Sesotho, but English is also recognised as an official language in Lesotho. As a result, the interview guide was developed in English and translated into Sesotho to create a more comfortable interview setting that would not limit the participants’ expression. During the interviews, the participants were allowed to code-switch and express themselves in the language they felt most comfortable with. The majority primarily used Sesotho, occasionally incorporating English when they deemed it appropriate. All the interviews were recorded on an audio recorder, and I later transcribed and translated them verbatim into English.

The initial interview was successfully conducted in June 2025, followed by subsequent interviews in July and August 2025. The interviews lasted between 25 and 45 minutes. Before each interview, the participants were reminded that they were free to pause or withdraw at any time if they felt uncomfortable. This was an important point to raise, given the study’s sensitive nature. At the end of each interview, the participants were asked whether they felt aggrieved and required the services of a professional counsellor. This was done to uphold research ethics, given the potentially triggering questions that may arise during the interview. Fortunately, none of the participants experienced psychological distress during the interviews.

Ultimately, this study used one-on-one telephonic and face-to-face interviews instead of focus group discussions for data collection. These methods were better suited for maintaining confidentiality due to the sensitive nature of the topic. In group settings, some participants might be uncomfortable sharing their thoughts openly. Additionally, these methods allowed each participant to express their opinions independently, avoiding influence from others, as highlighted by the Asch conformity experiment (Capuano & Chekroun, 2024). Larsen (1990) explains that the Asch experiment showed that individuals often conform under pressure from a majority, even if they disagree. By conducting one-on-one semi-structured interviews, each participant was afforded an equal opportunity to express their opinion freely and honestly, without fear of intimidation or being overshadowed by others. This research approach also supported the application of the HBM, which focuses on understanding why people engage in

or avoid specific preventive sexual healthcare behaviours. The participants seemed more comfortable and confident sharing their experiences privately, especially given the sensitive topics of family planning and HIV prevention, than they would have been in a group of strangers.

3.6 Data-analysis method

I began analysing the first dataset immediately after completing the initial face-to-face interviews, in line with Palmer and Coe's (2020) recommendation that analysis can begin as soon as the first set of interview data becomes available. In this study, thematic analysis was adopted to analyse data gathered from all 12 interviews. Thematic analysis is widely recognised as a systematic method for identifying, analysing, and interpreting patterns of meaning in qualitative data (Clarke & Braun, 2017). Guest, MacQueen and Namey (2012) highlight that thematic analysis focuses on uncovering both implicit and explicit ideas in the data, referred to as themes, rather than simply counting words or phrases. This approach assumes that recorded narratives or textual data serve as the foundation for analysis and that codes are developed inductively as salient patterns emerge through the researcher's engagement with the data. Table 3.2 presents an example of how Braun and Clarke's (2006) thematic analysis was conducted in this study.

Table 3.2: Example of code and theme development

Pseudonym	Direct quote	Code(s)	Subtheme(s)	Theme(s)	Theme definition
Mosa	"I believe PrEP can make people feel overly confident, almost as if they are wearing a bulletproof vest. Some might think they can have sex with anyone they want without worrying about HIV or pregnancy, especially if they are also using family planning. So yes, I think it could affect behaviour."	Risk Compensation Belief, Overconfidence, Risky Sexual Behaviour Concern, False Security Perception, Individual Differences in PrEP Response	**Behavioural impact of PrEP** Definition: Opinions on whether PrEP can influence an adolescent's sexual behaviour or not	**Attitudes towards PrEP use**	Beliefs, willingness, and perceived appropriateness of PrEP use
Mapule	"Oftentimes, when people know that you are taking PrEP, they are quick to assume that you have HIV and all. Things they say will discourage you. So, I do not think it matters. They are not going to change anything."	Stigma-Induced Discouragement, HIV Association with PrEP Use, Autonomy and Self-Determination, Resisting Social Pressure	**Community perceptions of PrEP users** Definition: The opinions held towards people who use PrEP	**Perceived social risk and stigma**	Social concerns and anticipated stigma related to PrEP use
Lerato	"You have to take the pills every day at the same time, without skipping. If you do not want to continue, you can stop and throw them away. The health workers give you the pills, but whether you take them or not, it is completely up to you."	Adherence Requirements, Autonomy in Medication Use, Role of Health Workers, Self-Determined PrEP Disposal Treatment Responsibility	**PrEP administration** Definition: An understanding of how PrEP should be taken to work effectively	**PrEP knowledge and misconceptions**	Understanding and misinformation about how PrEP works and its effects

I adhered to Braun and Clarke's (2006) six-phase framework for thematic analysis, which involves (1) familiarising oneself with the collected data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final report. During the first phase of familiarising myself with the data, I organised the audio recordings and field notes to begin the verbatim transcription process, followed by translation into English, as some interviews were conducted in Sesotho and the participants frequently code-switched between Sesotho and English. Being fluent in both languages enabled me to translate the Sesotho transcripts into English. To develop a deep understanding of the data, I immersed myself in the datasets by revisiting the field notes, repeatedly reviewing the translated transcripts, and listening to the audio recordings multiple times. For instance, in Table 3.2, the raw participant quotes and field notes facilitated familiarity with the datasets.

As I became more familiar with the data, I moved to Phase 2 and began coding manually using Microsoft Excel. As demonstrated in Table 3.2, I created a table with columns labelled pseudonym, direct quote, code(s), subtheme(s), theme(s), and theme definition. Throughout the analysis, it was essential to keep the study's research questions in mind to identify relevant codes and themes. A line-by-line coding method was then employed to ensure sufficient coverage of the responses. For each participant, a direct quote was inserted, and multiple codes were generated as applicable, aligned under their relevant themes. In Phase 3, when searching for themes, the four research questions were categorised into four overarching themes, and subthemes emerged from the data during coding. In Phase 4, the themes were reviewed to assess whether they adequately covered the study's objectives. Because the research questions were used to develop themes, none were discarded during this review. In Phase 5, each theme was assigned a name and given a clear definition. Related codes were then clustered into subthemes, which were clearly defined, as shown in Table 3.2. ATLAS.ti, a computer-assisted qualitative data analysis software, was employed to assess whether code and theme saturation had been achieved, as recommended by Smit and Scherman (2021), to organise the data and enhance analytical rigour. The software assisted in identifying an additional subtheme related to condom use among adolescent girls. In Phase 6, a final report of the thematically categorised findings was produced as the last step.

3.7 Ethical considerations

In research, the importance of respecting participants and avoiding deceptive data-collection methods, such as misrepresenting or providing incomplete information about the study merely

to secure their participation, cannot be overstated. Babbie (2016) highlights the necessity for researchers to openly identify themselves and avoid concealing their true role and aims. Accordingly, when informing the participants about the study's objectives, potential risks, and other pertinent details, I identified myself as a master's student at UNISA who was conducting research in fulfilment of my degree requirements.

Research ethics form the moral foundation of a study and encompass principles that guide interactions with participants, foster trust and rapport, and protect participants' rights (Rana, Dilshad & Ahsan, 2021). Qamar (2018) explains that research ethics provide a set of rules that govern the researcher's conduct from the inception of the study to the dissemination of the findings. Guided by these ethical principles, I committed to safeguarding voluntary participation, providing and clearly explaining information sheets, obtaining informed consent, and rigorously upholding confidentiality, safety, and respect for all participants throughout the research process and beyond (Vanclay, Baines & Taylor, 2013). Given the sensitivity of the topic under study, it was significant to follow ethical guidelines to ensure that the participants were not harmed in any way.

Given that the study involved human participants and was classified as high risk, data collection began only after permission was granted by the relevant research ethics committees in Lesotho and South Africa. Ethical clearance was first sought from the Lesotho Ministry of Health Ethics Review Committee, which, when necessary, forwards applications to the National University of Lesotho Institutional Review Board for additional review. Once both bodies had approved the protocol (approval reference: ID 159-2025; see Appendix B), a further application was submitted to CoHiP SEC for permission to conduct the study in its Berea precinct with adolescent girls accessing family planning services at its clinics. Approval was granted (see Appendix C). Finally, an application for ethical clearance was made to the UNISA College of Human Sciences Research Ethics Committee, with all prior approvals appended. Interviews with adolescent girls commenced only after clearance was granted by UNISA's College of Human Sciences Research Ethics Committee (approval reference: 240816-052 Ref: 6956; see Appendix A).

In undertaking this study, I was acutely aware of the ethical and practical complexities of working with adolescent populations. I recognised that factors such as peer pressure, the desire for external validation, preoccupation with other priorities, and a general reluctance to engage in activities that require time and commitment could shape how young people perceive and

respond to research participation. These considerations heightened my responsibility to communicate information about the potential risks and the meaning of informed consent concisely, clearly, and in age-appropriate terms, while being respectful of their ability to make informed decisions. Those who gave consent to proceed with the interviews, both on-site and by telephone, were requested to sign the consent form, with a clear understanding that the interviews would be audio-recorded and that no remuneration should be expected for participating.

3.7.1 Informed consent and voluntary participation

Guided by strong ethical principles, the study prioritised the protection of the participants by obtaining written informed consent from all the participating adolescent girls before data collection commenced. Informed consent was treated not merely as a procedural requirement but as an ongoing ethical process to ensure that the participants were fully aware of the study's purpose, potential risks, anticipated benefits, and their rights, including the freedom to decline or withdraw at any stage without adverse consequences. This approach was particularly critical given the sensitive nature of research involving adolescents, in which respect for autonomy, protection from harm, and the promotion of trust are central to upholding ethical integrity. Informed consent refers to participants voluntarily agreeing to take part in a study with a full understanding of its potential implications and the contribution they are making by participating (Vanclay et al., 2013). To achieve this, the objectives of the study were clearly articulated, potential risks such as emotional triggers and inadvertent disclosures were transparently communicated, and the intended use of the collected data was described. Each participant received an information sheet (see Appendices D and E) that outlined the study's objectives and expectations for participation. Questions and concerns related to this study were addressed to ensure that the participants were fully informed before agreeing to participate.

As participation was voluntary, the adolescent girls were informed that they could withdraw at any point during the study without fear of prejudice, ill-treatment, or any negative consequences. Furthermore, in line with Vanclay et al. (2013), explicit permission was sought for audio recording, and the participants provided written consent. Once the participants were fully informed of the study and agreed to participate, they were asked to sign an informed consent form (see Appendices F and G). The purpose of the study was reiterated, and the participants gave consent for audio-recording the interview sessions.

3.7.2 Confidentiality, privacy, and anonymity

Another key ethical consideration was ensuring the anonymity and confidentiality of all the participants. It was important to safeguard all demographic or identifying details and to take deliberate measures to ensure that this information remained strictly confidential and anonymous. Consistent with UNISA's (2016) ethical guidelines, it was also essential to acknowledge the ethical responsibility to protect any information that could reveal the identities of the participants. Furthermore, adolescent girls were likely to participate when assured that their identities would remain anonymous (Vanclay et al., 2013). For this reason, the use of real names or contextual information, such as the exact name of their village or where they worked or attended school, that could lead to identification was strictly avoided.

To uphold confidentiality, each participant was assigned a pseudonym, and any specific identifying details, such as the names of villages they were from in Berea, were withheld. All physical documents were securely stored in a lockable home desk that no one else could access except me. To safeguard digital data, including interview recordings and transcripts, a password-protected folder was created on a personal computer, using a uniquely generated password that was stored under an inconspicuous name on a mobile phone to prevent accidental disclosure. All digital data were backed up on a Google Drive account with a strong password to ensure an additional layer of protection.

To further maintain the confidentiality and anonymity of the participants, the interviews were conducted in a safe, private space at the CoHiP SEC clinic in Berea during their visit for family planning services. The interviews were one on one, which further protected the adolescent girls from inadvertent disclosure likely to occur in group discussions or door-to-door home visits. Other participants were interviewed by telephone. This method also ensured the participants' confidentiality because it allowed them to select a convenient time when they could speak freely in a private setting. Meeting the participants in person at the CoHiP SEC clinic, as they came for services, allowed for rapport building, even with those who ended up being interviewed telephonically.

3.7.3 Non-maleficence

Another significant ethical obligation for researchers is to ensure that participants are not subjected to any kind of harm (Dooly, Moore & Vallejo, 2017). In keeping with the principle of non-maleficence, I undertook to anticipate and mitigate any physical, psychological, social,

or cultural risks that might arise during the research process. I was particularly mindful that discussions surrounding family planning and PrEP could evoke emotional triggers or discomfort, as they relate to one's personal sexual activity, values, and beliefs. Recognising the sensitive nature of these topics for adolescent participants, the interview questions were carefully framed in a manner that was age-appropriate, non-judgemental, and culturally respectful, while also allowing the participants the freedom to decline to answer questions that made them uncomfortable. To minimise potential harm, referral arrangements with CoHiP SEC community counsellors were established, thus ensuring that psychological support would be accessible should any participant experience psychological distress. This approach not only reflected ethical best practices but also demonstrated commitment to conducting research that prioritised care, respect, and participant well-being. At the end of each interview, the participants were asked whether they needed any counselling services for possible traumas or triggers they may have endured during the interview. Luckily, none of the participants experienced any psychological distress, and they did not deem counselling services necessary.

3.7.4 Beneficence

Beneficence, as a core ethical principle, emphasises the obligation to maximise possible benefits and minimise potential risks while acting in the best interests of participants and ensuring that the research process contributes positively to their well-being and dignity (Bifarin & Stonehouse, 2022). As a researcher, I recognised the importance of treating each participant with respect and dignity throughout all the stages of the research process, from recruitment to data collection and dissemination. For instance, when one participant who had requested a telephone interview experienced a situation where a baby was crying near the phone, I responded politely and respectfully by suggesting that we reschedule the interview to a more convenient time. I was careful to communicate this in a way that did not make her feel uncomfortable or embarrassed about the circumstance. Such actions reflected a deliberate commitment to minimising potential stress or inconveniences for the participants while reinforcing their autonomy.

Deliberate efforts were made to consider the preferences of the participants and concerns regarding their participation, such as allowing them to choose whether the interviews were conducted face to face or by telephone, as well as the times that best suited them if they preferred the telephone method. This flexibility acknowledged the personal circumstances of the adolescent participants and aligned with the principle of beneficence by ensuring that their

comfort and agency were prioritised. The language used in the interviews was respectful and culturally sensitive to minimise discomfort, especially when translating questions from English to Sesotho. By doing so, I not only reduced the risk of misinterpretation but also created a safe, inclusive environment that enabled the participants to share their experiences authentically and without fear of judgement. Ultimately, these efforts ensured that beneficence was applied as a lived ethical practice rather than an abstract principle, which reinforced the integrity of the study and enhanced the trustworthiness of its findings. The findings of this study will benefit adolescent girls who use family planning services and are at risk of HIV through programming that addresses the social challenges that hinder their PrEP uptake.

3.8 Reliability and trustworthiness of the study

3.8.1 Reliability

Reliability and validity were essential for establishing and demonstrating the rigour of the research process and the credibility of the findings (Roberts & Priest, 2006). Reliability refers to the consistency of a measurement tool, specifically its ability to produce the same results on different occasions (Bannigan & Watson, 2009). In undertaking this research, I recognised the importance of ensuring reliability not only to enhance the quality of the study but also to build confidence in this research in the academic community. To achieve this, all methodological procedures were systematically documented so that other researchers could replicate the process or identify a point of departure for their own research undertakings. All interviews were recorded and securely backed up to password-protected storage. In addition, verbatim transcriptions and translations of the participants' responses were carefully conducted, maintaining consistency in developing and applying definitions for codes and themes.

Ensuring validity was equally critical to this research due to the awareness that interpretations could be influenced by personal assumptions or biases. To address this, I employed several strategies to enhance the reliability and validity of the study. For instance, a member-checking exercise was undertaken by summarising key points during the interviews to confirm that the participants' opinions were well understood. A reflexive journal was kept throughout the data-collection process to critically examine my positionality and how it might shape the data interpretation. Furthermore, peer debriefing was sought with the academic supervisor, which provided external scrutiny of coding and theme development to ensure that interpretations were grounded in the participants' narratives rather than preconceived notions. These deliberate

efforts reflected the study's commitment to methodological rigour and the ethical responsibility to produce trustworthy and credible findings.

3.8.2 Trustworthiness

In qualitative research, the concept of trustworthiness relates to the overall quality of a study. To ensure trustworthiness, the research design needed to be rigorous, integrity had to be demonstrated, the findings had to be truthful and free from falsification, and the methodologies employed had to be appropriate for the research objectives (Rose & Johnson, 2020). The goal of trustworthiness in a qualitative inquiry is to demonstrate that the findings are credible, meaningful, and worthy of consideration, which are often assessed using the criteria of credibility, transferability, dependability, confirmability, and authenticity (Elo et al., 2014).

In interpretive phenomenology, the researcher's role is not detached but deeply embedded in the research process. I acknowledge that as a student researcher undertaking research within my own socio-cultural context, my background, values, and assumptions could have influenced both my engagement with the participants and my interpretation of their experiences. Recognising this, I made a conscious effort to mitigate bias and enhance confirmability by maintaining a reflexive journal throughout, as previously mentioned. In this journal, I documented my evolving thoughts, methodological decisions, and reflections on interactions with the participants. This reflexive practice allowed me to evaluate my thinking around the study and to remain as objective as I possibly could.

3.8.3 Credibility

To ensure credibility, researchers must accurately identify and describe participants in their research (Elo et al., 2014). In this respect, the study's participants were adolescent girls aged 18 and 19, residing in Berea, Lesotho, and who were utilising community-based family planning services provided by a non-governmental organisation. Phenomenological research encourages repeatedly engaging with transcripts, relying on verbatim accounts, and continually checking interpretations as key practices for enhancing credibility in interpretive phenomenology (Annamalai et al., 2022; Sinfield, Goldspink & Wilson, 2023). Consequently, I ensured that the findings accurately represented the participants' realities by frequently reviewing data and attentively revisiting the transcripts during analysis. Member checking was undertaken by summarising key responses during the interviews to confirm the participants' intended meaning. These strategies reduced the risk of misinterpreting the participants'

responses. I remained mindful of Vella's (2024) caution about relying too heavily on member checking and applied it only to clarify meaning rather than to validate the interpretations.

3.8.4 Transferability

Transferability refers to the extent to which research findings can be applied across different settings or population groups (Elo et al., 2014). To enable readers to assess the applicability of the findings to other contexts, I provided detailed descriptions of the research design, participant characteristics, and the socio-cultural environment in which the study was conducted. This detailed contextualisation may enable other researchers to determine the applicability of the findings to their own contexts. Consistent with phenomenological literature, thick, context-rich accounts were included to enable readers to ascertain the transferability of the findings of this study based on the depth and detail provided (Davoodi et al., 2022; Annamalai et al., 2022). Johnson, Adkins and Chauvin (2020) argue that transferability can be further improved through detailing contextual variables such as environments, peer networks, and family structures identified as key influences on adolescent PrEP decision making. In this study, the majority of the participants lived in urban areas, with only four of the 12 coming from rural communities. This distinction matters because, as the findings demonstrate, these different settings shape how adolescent girls encounter SRH information and access related services.

3.8.5 Authenticity

I endeavoured to represent the participants' voices faithfully and inclusively. This involved presenting nuanced accounts that captured the diversity of perspectives, including those that challenged my own assumptions. By doing so, I ensured that the findings conveyed an authentic picture of the participants' lived experiences. Phenomenological literature highlights that authenticity is strengthened through reflexive openness, transparency about the researcher's positionality, and the presentation of both convergent and divergent participant narratives (Høffding, Martiny & Roepstorff, 2022; Moser & Korstjens, 2023). These principles guided the interpretive stance adopted in this study. In the context of PrEP uptake, authenticity was additionally enhanced by ensuring that both positive and negative attitudes towards PrEP were represented, including accounts of fear, misinformation, empowerment, and negotiation of sexual health, which are areas that are deemed essential in the analysis of adolescent health behaviour (Alhazmi & Kaufmann, 2022).

3.8.6 Confirmability

Confirmability refers to the degree of objectivity, which means the potential for agreement among two or more independent individuals regarding the accuracy, relevance, or meaning of the data (Elo et al., 2014). In this study, confirmability was ensured by maintaining detailed records of all research procedures and the consent forms of each participant. Accurate translations and transcriptions of participant responses were made, and duplicate recordings were retained as backups. To further strengthen confirmability, an analytic audit trail documenting coding decisions and thematic development was maintained, which is consistent with best practices recommended in recent phenomenological methodology sources (Sinfield et al., 2023; Vella, 2024). Reflexive notes were also integrated into the audit process to demonstrate how interpretations evolved over time.

3.8.7 Dependability

Dependability refers to the consistency of data over time and across various conditions (Elo et al., 2014). To accomplish this, a detailed explanation of the criteria used to select the participants was provided, along with a detailed description of their key characteristics. I aimed to demonstrate the stability and consistency of the research process over time. As a result, I kept an audit trail by carefully recording methodological choices, interview processes, coding schemes, and changes made throughout the research. This transparency creates an opportunity for scrutiny by other researchers and potential replication. In addition, peer debriefing with the supervisor served as an external checkpoint to enhance analytic consistency.

3.9 Reflections of the researcher

Since phenomenological research is socially constructed and shaped by the researcher's use of different interpretive lenses (Patnaik, 2013), recognising and disclosing one's biases is essential for ensuring the credibility and trustworthiness of data collection and analysis in these study designs (Johnson et al., 2020). Reflexivity is therefore an essential component of interpretive phenomenological research, as it requires the researcher to critically examine how their positionality or worldview, assumptions, and experiences shape data collection, analysis, and interpretation (Olmos-Vega et al., 2023; Oluka, 2025). Additionally, being open about one's own point of view is crucial because the researcher functions as a means through which interpretations are produced (Tracy, 2024). Reflexivity therefore emphasises that the researcher

is an active participant in constructing knowledge, rather than a detached, external observer of the phenomenon under scrutiny (Patnaik, 2013). Consequently, while constructing knowledge, the researcher may reflect on how their interest in a topic developed, what assumptions they carried into the study, and how their understanding shifted as they engaged with the participants (May & Perry, 2022).

My interest in this study began during a work meeting when it was reported that new HIV cases had been recorded among adolescent girls in Berea. The report also noted that these girls were utilising contraceptive services more than they were using PrEP, even though both were offered at the same location. I wondered why the adolescent girls would exclusively choose to take contraceptive services and decline PrEP when they were having unprotected sex, especially with HIV cases emerging in the same age group. I was determined to identify the underlying factors to make recommendations that could enhance their health outcomes. Approaching the research, as Maake (2021) asserts, I was aware that I was not a "clean slate" as a researcher, but that I carried pre-existing worldviews into the field.

As I conducted the research, I realised that, as a man, it was challenging to engage adolescent girls on certain topics related to their sexual activity. These difficulties arose from my own cultural inhibitions and discomfort discussing sex, particularly with young girls. Nonetheless, I drew from my prior work experience in adolescent health, which helped me to find culturally sensitive ways to ask difficult questions. For example, instead of asking whether a participant used condoms, I inquired how they went about preventing contracting HIV.

Although my gender never seemed to deter the girls from sharing information, I noted in my field journal that perhaps some participants might have been more forthcoming in their responses had the interviewer been a woman. For instance, as a way to determine the HIV risk factors among adolescent girls, they were asked about their reasons for using family planning. One participant hesitated in her response, not in awkward discomfort, but almost as if she would say more if she could. This made me reflect on whether the fact that I am a man caused the participant to withhold some details in her responses. I was cautious not to make the participants feel pressured in my probing. Moreover, I was intrigued by one adolescent's response that her use of contraceptives was a result of not using condoms and being in sexual relationships with several partners, but she was still unwilling to take PrEP. Coming from the perspective of a person who has worked in the health space for a long time, I felt compelled to offer advice. I documented in the field journal the fleeting thoughts of pity that came to mind

during this interview. Reflecting on these experiences in my field journal reminded me that imposing my moral judgements, values, or expectations could unduly influence the participants' accounts. Therefore, I learned to allow the participants to share their lived experiences in their own way. Another participant sought relationship advice involving an older man during the interview. However, because I was mindful not to influence the interview in any way, I politely requested that we suspend the question until after the interview. I had to reflect on the boundaries of my position as a researcher in this instance. Offering advice could blur the line between researcher and participant, which could potentially compromise the integrity of the data and the ethical framework that guided the study. Providing direct advice could inadvertently shape the participant's personal choices in ways I am neither qualified nor ethically authorised to do. Instead, I focused on how to recognise and validate their emotions in a respectful manner without crossing into a therapeutic role. I responded by calmly steering the discussion back to the research topic while acknowledging and affirming the participant's feelings. I also noted in my field journal how this interaction revealed the complexity of interviews as social encounters, where participants may seek more than just a platform to share research-relevant experiences.

3.10 Conclusion

This chapter described the methodological basis of the study, which employed an interpretive phenomenological approach within a qualitative research framework to explore the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho. The chapter outlined how purposive sampling was employed to recruit 12 research participants who could provide the required information and valuable insights through one-on-one, semi-structured interviews conducted both in person and via telephone. Furthermore, a description of the data-analysis process was provided, which highlighted how Braun and Clarke's (2006) thematic analysis method was utilised in the study to facilitate the systematic identification and interpretation of themes and patterns from the participants' own accounts. To ensure the trustworthiness of the study, I unpacked how credibility checks, extensive journaling, and adherence to ethical standards were implemented throughout the research process. Reflexivity played a key role in the methodology. The chapter concluded with a discussion of how I critically reflected on and assessed my personal assumptions and positionality to reduce bias and maintain the integrity of the findings.

The next chapter presents and discusses the findings of the study.

CHAPTER 4:
FINDINGS AND ANALYSIS

4.1 Introduction

Berea has an estimated population of 262 616 people, with 24 001 believed to live in villages surrounding the district's capital, Teyateyaneng. Most residents live in rural areas (Bureau of Statistics, 2016). In these rural settings, adolescent girls grow up under traditional norms that shape gender roles early on. Education levels tend to be lower among rural adolescents, and while teenage pregnancies are common, they are still met with disapproval. Access to schools, clinics, and water sources often requires walking long distances, which raises the risk of sexual abuse, especially since electricity infrastructure is limited and streets are dark at night. Consequently, adolescent girls face daily risks of pregnancy and HIV infection, but they are often reluctant to seek SRH services due to fear of judgement and community ridicule. In these areas, young girls find it difficult to discuss sexual intercourse with their parents because it is considered taboo. However, when mothers worry that their daughters might be of dating age and vulnerable to pregnancy, they sometimes recommend SRH services. Yet, girls seeking these services are often labelled as promiscuous or uncultured, which discourages them from approaching their parents for information. Instead, they tend to turn to friends or healthcare professionals during community outreach programmes for guidance. As families move to more urbanised villages, they carry with them the same beliefs and attitudes that are ingrained in their rural upbringing.

Following this brief overview of the participants' social backgrounds, this chapter presents and analyses the qualitative findings derived from face-to-face and telephonic interviews with 12 adolescent girls who use family planning services from CoHiP SEC in Berea, Lesotho. The chapter discusses how knowledge, beliefs, and attitudes regarding PrEP, perceived stigma, and access to PrEP inform adolescents' decisions to use it. Before delving into that discussion, it is imperative to first explore the lived experiences and motivating factors that influence the use and adherence to family planning services among adolescent girls aged 18 and 19 years in Berea, Lesotho. The chapter begins by discussing how adolescent girls acquire SRH information, what motivates them to use family planning services, and the factors they consider when disclosing the use thereof. The discussion then moves to what adolescent girls know

about PrEP and their beliefs and attitudes towards it, which were found to inform the ultimately low uptake among this demographic.

4.2 Theme 1: Narratives of Basotho adolescent girls concerning family planning use

Access to information is an important factor that influences what participants know and how they interact with healthcare services. This study found that adolescent girls in urban and rural areas of Berea rely on various information sources that differ in trustworthiness and reliability when making health decisions. For adolescents like Mosa and Mapule, who live in the urban villages of Berea, social media platforms and the branding of services on windows, gazebos, and T-shirts have helped to increase their awareness of available SRH services. Mosa and Mapule explained:

> *"I first learned about family planning services through social media. Then, maybe because I had heard about it, I saw it again sometime in a newspaper article, and on the radio"* (Mosa, 19 years, June 2025).

> *"I was just passing by when I saw a couple of ladies wearing the same printed T-shirts outside under a branded tent, talking to people about family planning services. That's how I first heard about it. They explained everything to me, and that's when I decided to come back and access the services"* (Mapule, 19 years, July 2025).

Unlike adolescent girls in the USA and Europe, who rely on health professionals and their parents to learn about SRH (Pleasants et al., 2024), this study found that participants from the urban areas of Berea used mass media to acquire SRH information. These methods allow adolescent girls the discretion to access available information at their own pace, such as through social media, branding, and leaflets. Social media enables adolescents to search for content they find appealing, while print media allows them to decide which parts to read and when. In line with the perspective of the HBM, these narratives illustrate the role of cues to action, as exposure to branding and leaflets serves as a visual reminder of available services, while online information acts as an additional trigger that prompts awareness and potential consideration or rejection of PrEP and family planning services. These cues play a significant role in shaping how adolescent girls perceive their susceptibility to pregnancy and HIV, as well as the benefits of using preventive strategies. These findings align with those of Mulubwa et al. (2021) and Chola, Hlongwana and Ginindza (2023), who argue that passive mass messaging, such as

branding, leaflets, and radio, alongside other active social media cues, operates as critical cues to action, with social media often widening reach but also raising concerns about the accuracy of the shared information.

Exposure to branded materials and direct interactions with trained service providers encouraged the participants to consider using family planning services. The findings indicate that although many sources of information are accessible to adolescent girls, many participants in rural areas became aware of SRH services primarily through community outreach campaigns conducted by trained personnel. Grace, Dudu, and Reteng appeared to prefer community outreach for learning about family planning services, as demonstrated below:

> *"Ummm… from health promoters who bring services to us in the communities during outreach programmes. They called a public gathering with the village chief for all youths, and they would teach us about the services"* (Grace, 18 years, August 2025).

> *"I think when I first heard of these services, it was through health promotion activities at my village. There was an outreach, and the health promoters came to us directly to our homes"* (Dudu, 18 years, August 2025).

> *"It was through a community outreach in my village. They have this huge truck that they use to offer services, so they would stop and talk to us about family planning"* (Reteng, 19 years, August 2025).

The participants emphasised the importance of community outreach campaigns and home-based health promotion in increasing awareness of family planning and HIV prevention. Unlike passive methods such as branding or social media, direct engagement through personal contact and proximity enhances adolescents' access to credible information. In line with Molefe and Nyangu (2025), this study's findings reveal that community outreach offers adolescents opportunities to interact with trained healthcare providers without travel or service costs. These efforts are especially effective because they target specific groups through school visits, mobile clinics, public gatherings, and service providers that sometimes employ door-to-door strategies to ensure comprehensive reach. The emphasis on outreach and trusted, face-to-face contact is consistent with findings across sub-Saharan Africa, where community-based campaigns and mobile clinics increase perceived credibility and uptake. Research reveals that provider attitudes and the visibility of outreach teams strongly influence adolescents' willingness to engage with services (Sidamo et al., 2023; Ketye et al., 2024).

Unlike adolescent girls in parts of Europe, who use contraceptives to stop menstruation and improve acne (Ti et al., 2022), this study found that the participants cited different reasons for using family planning, such as sexual activity, relationship goals, and financial concerns. The main reason among the participants, however, was the desire to prevent unintended pregnancies, especially in cases of unprotected sex and multiple sexual partners. Reteng, who had an early sexual encounter, explained:

> *"[Laughs] Well, I started dating when I was in Grade 7, and most of the boys I date don't like using protection"* (Reteng, 19 years, August 2025).

Similarly, other participants used family planning services because they wanted more control over reproductive decisions, especially in patriarchal societies that influence gendered power dynamics. Using these services therefore gave them a sense of empowerment, particularly in age-disparate relationships. Kholu expressed:

> *"Hey! You know how it is out there... [pause] You just can't afford to have a child at a young age. I'm in a relationship with an older man, and he said he wants us to have a baby. But I don't want to marry him. There are some red flags with him. I don't trust him… I can't really explain it, but something doesn't feel right with him. I don't want to be a single mother... [laughing]"* (Kholu, 19 years, June 2025).

These narratives highlight an awareness among adolescent girls of their impending pregnancy risks when dating multiple men, who are sometimes older. For these girls, using family planning services empowers them to exercise control over their own bodies, especially when the societal norm dictates that men wield disproportionate power in relationships and have the final say in SRH decisions that affect women. Using family planning services therefore protects adolescent girls from the will of men, including those who are not in sexual relationships with them, as illustrated by the case of 18-year-old Palesa. She recognised that life in the rural areas where she lives involves significant risks, which drove her to use family planning services out of fear of sexual violence and concerns about cultural norms that associate pregnancy with marriage. She explained:

> *"I decided to start using family planning because there's a high risk of falling pregnant unintentionally, including through incidents of rape. Where I live, it's still a rural area, and these things unfortunately still take place. Also, I don't want to fall pregnant while*

> *I'm still young, because that would mean getting married before I'm ready"* (Palesa, 18 years, July 2025).

Palesa was aware of the harsh realities faced by girls her age in rural communities, where sexual violence and child marriage are widespread. Sexual abuse is often perpetrated not only by strangers but also by individuals known to the girls, including neighbours and family members. At the same time, many adolescents find themselves in toxic intimate relationships where partners sometimes refuse to use condoms. In both contexts, the findings indicate that some participants turn to family planning services as a means of preventing unintended pregnancies that might occur against their will. In some rural areas of Lesotho, cultural norms dictate that a man who impregnates a girl outside of marriage is expected to pay damages to her family and marry her (UNICEF, 2021). Using family planning services therefore empowers adolescent girls like Palesa to maintain autonomy over their bodies and reproductive health, even in the unfortunate event of sexual abuse. These findings align with those of Ajayi and Ezegbe (2020) and Moloi and Malapela (2024), who report that the fear of sexual abuse motivates the use of family planning.

When asked about their willingness to disclose their use of family planning, two participants echoed the view of 19-year-old Praise, who stated:

> *"Yes, my partner and I discussed it and agreed it would be a good idea to start using something that would allow us to get intimate without worrying too much about a baby"* (Praise, 19 years, July 2025).

Four participants reported being comfortable discussing their contraceptive use with family and friends to gain support, as these are the people who likely encouraged its use in the first place. Five participants chose not to reveal their use of family planning to anyone due to concerns about being judged by family or peers, as well as worries that their partners might become complacent and neglect protective measures. For instance, Grace said:

> *"As in my boyfriends? No, [I disclosed to] a friend. I have not disclosed to my boyfriends, because they will get too comfortable and do things freely. But I told my friend because she is the one I do these things with, and we do these things together. In fact, she uses them too"* (Grace, 18 years, August 2025).

These narratives demonstrate distinct patterns of disclosure regarding the use of family planning services among adolescent girls. Disclosure decisions were largely shaped by

interpersonal relationships, perceived levels of social support, and anticipated stigma. The participants who disclosed their contraceptive use to their partners demonstrated trust and a willingness to share responsibility for pregnancy prevention. Those who confided in family members or friends viewed their social networks as protective spaces that normalised and validated their use of family planning services. Such openness potentially reflects the desired progress whereby discussions of SRH are accepted and less stigmatised. In contrast, the majority of the participants chose not to disclose their contraceptive use, citing fears of judgement and concerns that partners might decide to stop using protection. These findings align with evidence that indicates that fear of judgement, cultural norms, and partner dynamics are key determinants of non-disclosure among adolescent girls (Sidamo et al., 2023; Ketye et al., 2024).

The findings reveal that, although the primary motivation for the participants to use family planning was essentially to avoid unintended pregnancies, other factors, such as fear of sexual assault and early marriage, also contributed to their decision. Many participants used contraceptives as a calculated reaction to economic dependence, pressure from older partners, gendered power disparities in relationships, and the persistent threat of sexual violence, all of which increase their vulnerability to HIV. The findings demonstrate that adolescent girls in the study were at high risk of HIV because of the same cues that drive them to seek protection against pregnancy, such as early encounters with sex, multiple sexual partners, cultural norms that restrict girls' bodily autonomy, and partners' refusal to use condoms. However, concerns about partner complacency and disclosure issues impose further limitations that restrict open communication and encourage secrecy that could compromise comprehensive protection. These findings suggest that, although adolescent girls actively use family planning as a means of personal protection, their HIV prevention requirements are nonetheless linked to the same vulnerabilities that influence their choices about contraception. It was therefore essential to draw this understanding before discussing why the uptake of PrEP is low among adolescent girls who use family planning, despite their susceptibility to HIV infection.

4.3 Theme 2: Adolescent girls' knowledge about PrEP in Berea

Having examined the factors that motivate adolescent girls in Berea to use family planning services and how these same factors increase their vulnerability to HIV, this section explores the extent of their PrEP knowledge to mitigate their exposure. It further considers how information about PrEP, including perceived benefits and drawbacks, understanding of its

administration, and the beliefs held by influential others, might shape their perception of PrEP use. Examining these aspects was essential in determining whether what adolescents know about PrEP contributes to the overall low uptake observed among them.

4.3.1 Subtheme 2.1: Sources that inform PrEP knowledge among adolescent girls

The findings of this study indicate that all participants, except Palesa, were aware of PrEP as an HIV prevention option. Palesa's lack of awareness regarding PrEP points to a missed opportunity for the clinic to integrate PrEP counselling when she presented for family planning services. This might also reflect broader implementation silos in SRH and HIV prevention service delivery in Berea. Among the participants who were aware of PrEP, sources of information varied in formality and credibility, which ranged from Internet sources to trained health professionals. For instance, while 19-year-old Mosa learned about PrEP from social media platforms and the radio, 19-year-old Lethabo learned about it from nurses during her antenatal care visits. Although health professionals are typically well-informed and reliable sources of accurate information, Garett and Young (2022) note that misinformation remains widespread and poses risks to both individual health behaviours and public health. Misinformation is amplified by the rapid expansion of social media, where weak content regulation allows misleading, false, and harmful information to spread easily (Garett & Young, 2022). Therefore, while information obtained online requires careful consideration, Internet-based sources play a significant role in enhancing awareness among adolescent girls, such as Mosa, who spend considerable time engaging with social media platforms on their phones.

Kholu first learned about PrEP through casual conversations with friends in her social circle. Although informal, these interactions nonetheless contributed to her initial awareness of PrEP. In accordance with the TPB that guided this study, such influences are understood as subjective norms, which are the social pressures that shape an individual's intention to engage in or refrain from a particular behaviour due to the perceived expectations of significant others (Ajzen, 1991; Worthington, 2021). Depending on the nature of the conversation in which Kholu encountered information about PrEP, existing literature suggests that social approval or disapproval can significantly affect an individual's decision to initiate PrEP (Rugira et al., 2023; Chebet, McMahon, Tarumbiswa et al., 2023; Rousseau et al., 2021; Muhumuza et al., 2021).

In contrast, several participants, including Kabelo, Lerato, Reena, Grace, Dudu, and Reteng, reported first learning about PrEP from healthcare providers during community outreach

programmes. This highlights the crucial role of health promotion campaigns and healthcare workers in disseminating adolescent-appropriate, culturally sensitive PrEP information. For instance, Dudu explained:

> *"Yes, I know about PrEP, and PEP [post-exposure prophylaxis] too. One helps before being exposed to the risk of HIV, and the other is used after a person has been exposed to HIV. I heard about it from the same health promoters who came to my house"* (Dudu, 18 years, August 2025).

Likewise, Mapule learned about PrEP during an outreach programme and went further to become a PrEP ambassador to create demand for PrEP among other adolescents in Berea. Together, these narratives emphasise the importance of community outreach programmes, which provide adolescent girls with meaningful opportunities to engage with trained healthcare providers. These interactions enhance their understanding of PrEP and strengthen their capacity to make informed choices.

4.3.2 Subtheme 2.2: Assessing adolescents' applied knowledge of PrEP

To assess the knowledge that adolescent girls in this study had about PrEP and its potential influence on uptake, the participants were asked to describe the potential benefits and drawbacks of PrEP. While all participants, except Palesa, who did not know what PrEP was, agreed with 19-year-old Lethabo that *"it prevents the transmission of HIV from one person to another"*, Lerato believed that the pills could be discarded whenever the user gets tired of taking them:

> *"PrEP helps reduce the chance of getting HIV, so you can't get HIV if you take it correctly. You have to take the pills every day at the same time, without skipping. If you don't want to continue, you can stop and throw them away. The health workers give you the pills, but whether you take them or not is up to you. Their job is just to provide the pills"* (Lerato, 19 years, July 2025).

Although Lerato was correct in her description that PrEP reduces the risk of HIV when taken correctly every day, her belief that PrEP can be discontinued at will and discarded without consulting healthcare workers is problematic and raises concerns. This demonstrates a misunderstanding of "on-demand PrEP" where instead of taking PrEP daily, two pills are taken 24 hours before sexual intercourse, one pill 24 hours after the first dose, and the last pill 24

hours after the second dose (CDC, 2025). Taking PrEP in the same manner as Lerato can be misleading because the service provider may assume that since she collected PrEP, she is taking it, when she may actually choose to discard it without having used it at all. In addition, this way of using PrEP might also contribute to a condition called antimicrobial resistance, where microorganisms like viruses and bacteria evolve and become resistant to medicines (WHO, 2023b). This means that premature discontinuation of PrEP without consultation can significantly compromise its effectiveness. As a result, the next time an adolescent resumes PrEP, the medication may provide reduced or potentially inadequate protection against HIV. However, Lerato's assertion that PrEP must be taken daily and at the same time aligns with what other participants believed was the correct way of administering PrEP. Reteng explained:

> *"You have to take it once a day, at the same time. If, for some reason you forget to take them at that time, whenever you remember, make sure to take them and go back to the same time the next day"* (Reteng, 19 years, August 2025).

Reteng's narrative demonstrates a clear understanding of how to use PrEP for effective use, which correlates with the guidance provided in the South African 2021 updated guidelines for the provision of oral PrEP to persons who are at substantial risk of HIV infection. The guidelines state that PrEP is most effective when taken daily, and if a dose is missed, the individual should take it as soon as they remember and then resume the usual once-a-day schedule (Health RSA, 2021). While other participants shared Reteng's view, they were unable to articulate what should be done when a dose is missed, as also highlighted by Muhumuza et al. (2021) in a study conducted in Zimbabwe, Uganda, and South Africa. This lack of knowledge might cause individuals to discontinue PrEP by default because they do not know how to proceed, or misuse it by overdosing, which can potentially cause adverse effects. Such effects may then be incorrectly attributed to PrEP itself rather than to improper use. There was also an inadequate understanding of the time it takes for PrEP to become effective. Mosa stated:

> *"... I am just not too sure how many days exactly, but if I recall correctly, it has to be between two to three days before"* (Mosa, 19 years, June 2025).

In contrast, the CDC (2025) suggests that it takes seven consecutive days for daily oral PrEP to reach protective drug levels for receptive anal intercourse and up to 21 days for receptive vaginal intercourse and for people who inject drugs. The participants' lack of knowledge may result in incorrect use of PrEP, which could expose them to the risk of HIV or lead to adverse effects.

The findings of this study further reveal that the participants reported similar side effects associated with using PrEP, including headaches, diarrhoea, or nausea. However, half of the participants did not have first-hand experience of these side effects and relied on what they had been told. Those with personal narratives of side effects experienced them differently. For instance, Mapule experienced an intense allergic reaction when she took PrEP but did not stop taking it at that time. She continued taking PrEP after all the side effects had resolved and only stopped using PrEP at a later stage when she entered into a committed relationship with a partner she trusted and with whom she regularly tested for HIV. In contrast, Reteng experienced nausea, fatigue, and a loss of appetite and decided to discontinue her use of PrEP as a result. In line with the HBM, the findings illustrate that when the perceived risk of HIV and the perceived benefits of using PrEP are high, negative experiences in the form of side effects are unlikely to discourage users from taking PrEP. Conversely, when the perceived risk of HIV and the perceived benefits of PrEP use are low, adolescent girls may feel discouraged from using and adhering to PrEP.

It was essential to evaluate holistically how the knowledge of PrEP among adolescent girls might affect their uptake. The findings indicate that most adolescent girls in this study shared a common understanding that PrEP is an effective HIV prevention option for individuals at risk of HIV, that it must be taken daily to work optimally, and that temporary side effects may occur. However, significant knowledge discrepancies remain, which can lead to incorrect use of PrEP. Such misuse might reduce its effectiveness and increase girls' vulnerability to HIV, particularly if they believe that they are sufficiently protected when they are not, or at least not to the full potential of PrEP. Moreover, if an adolescent girl acquires HIV while using PrEP incorrectly, this may fuel broader misconceptions about PrEP's overall effectiveness. The next section discusses how the opinions of others about PrEP might influence adolescent girls' feelings and views on PrEP.

4.3.3 Subtheme 2.3: The influence of peer and community perceptions of PrEP on adolescent girls

This section presents findings on how adolescent girls interpret other people's views on PrEP and use those interpretations to inform their own opinions. In some cases, adolescents may project their personal views onto others and express their opinions as though they belong to peers or community members. Assessing how adolescent girls believe others perceive PrEP can offer valuable insight into their underlying attitudes. In other instances, adolescent girls

may reference other people's views and try to align their views with those of their peers or reference groups. Understanding these dynamics helps to determine whether perceived social norms influence their personal perceptions of PrEP.

The findings of this study reveal a lack of open communication among peers for participants like Reena, Kabelo, and Palesa. They reported that they did not talk about PrEP, and were therefore unsure of their perceptions of it. For instance, Kabelo said:

> *"I'm not entirely sure how other girls feel about it because we don't really talk openly about such things"* (Kabelo, 19 years, July 2025).

This limitation in communication among peers might indicate a broader issue of a lack of trust and fear of judgement. Park et al. (2023) argue that when women sense stigma around the use of certain SRH services, even if they are not using them, they may refrain from discussing such topics to avoid judgement.

The findings of this study further indicate a notable dislike for PrEP among peers, which is consistent with results from similar studies conducted in Lesotho and Namibia by Chebet, McMahon, Tarumbiswa et al. (2023) and Ashipala (2024). While Praise reported not knowing the reasons why her peers and people in her community disliked PrEP, Mapule suggested that this dislike stemmed from internalised HIV-related stigma. She said:

> *"People assume that if you are on PrEP, you are HIV positive. They are narrow-minded. They'll ask why you take pills daily, like you're sick or something ..."* (Mapule, 19 years, July 2025).

Similarly, Mosa identified the same concern in service delivery. She said:

> *"I think some girls don't like to take PrEP because it's distributed where people living with HIV get their ARVs. That might lead others to assume that anyone collecting PrEP is HIV positive too, which can be discouraging"* (Mosa, 19 years, July 2025).

These narratives emphasise the participants' fear of PrEP-related stigma, which stems from conflating PrEP with HIV treatment and can lead to negative perceptions of PrEP among peers and other community members. The narratives illustrate how young people often assume that PrEP users are HIV positive because they take daily pills, which highlights how internalised HIV-related stigma shapes attitudes towards PrEP use. Likewise, Mosa's observation that PrEP is dispensed alongside ARVs shows how service delivery practices inadvertently reproduce

stigma by making ART patients queue separately from other patients. Such dynamics intensify fears of being seen and labelled HIV positive, which discourages adolescents from initiating or continuing PrEP. Having people living with HIV queue separately is potentially stigmatising, hence the fear of conflation among potential PrEP users. However, these findings align with Velloza et al. (2020), who argue that PrEP users in sub-Saharan Africa are frequently mistaken for being HIV positive because PrEP pills resemble ARVs. This misunderstanding contributes to anticipated stigma, which leaves users worrying about being perceived as HIV positive and thus prompting secrecy, reduced adherence, or discontinuation of PrEP (Obeagu & Obeagu, 2024).

In contrast, Grace described a positive perception of PrEP among her peers. This view was shared by Lethabo:

> *"I think it is something they have an interest in, because it addresses their need for HIV protection, considering things that happen at our age. It is more reliable than other means of HIV prevention"* (Lethabo, 19 years, July 2025).

These findings reveal that some community members and peers consider PrEP valuable in preventing HIV. The narrative that *"things that happen at our age"* indicates that adolescent girls in the study recognised their increased vulnerability to HIV due to developmental, social, and relational factors that are typical during adolescence. Adolescent girls are aware of their perceived risk of HIV and the potential benefits of using PrEP, which is consistent with the HBM that guided this study. There is also a preference for PrEP over condoms, potentially due to concerns about inconsistent condom use and reliance on a partner's cooperation. This positive perception of PrEP could normalise its use among adolescent girls and significantly reduce the stigma associated with it.

It was essential to examine how others' perceptions of PrEP might influence adolescents' attitudes towards it, given that adolescents often model their beliefs and behaviours after those of their peers and influential figures in their social networks. The findings suggest that adolescent girls' intentions to take up PrEP are significantly shaped by how they believe others perceive it. For some, limited peer communication and fear of judgement create uncertainty about social norms, which makes them hesitant to consider PrEP. Negative perceptions, often rooted in internalised HIV-related stigma and the conflation of PrEP with HIV treatment, lead many adolescents to worry that using PrEP will result in them being viewed as HIV positive. Service delivery practices that place PrEP alongside ARVs and separate from other patients

further reinforce these fears. Such anticipated stigma discourages uptake and openness about using PrEP. Conversely, some adolescents report positive attitudes among their peers, recognising PrEP as a reliable and appropriate HIV prevention strategy for the risks they encounter, which can help to normalise its use and mitigate stigma. Overall, the participants' perceptions of how others view PrEP significantly influence their willingness to use it. This finding is consistent with a review conducted by Chen-Charles et al. (2025) in sub-Saharan Africa, which identified social support, especially strong family and peer networks, as key facilitators of effective PrEP use that promote adherence and persistence. The following section discusses the beliefs and attitudes that adolescent girls have developed in relation to those of their peers and community members.

4.4 Theme 3: Social and psychological factors that affect PrEP uptake among adolescent girls

In an effort to understand the perceptions that adolescent girls have of PrEP use, this section explores their experiences with PrEP and the beliefs they hold about whom it is intended for. It further investigates adolescents' views on whether PrEP might influence their sexual behaviour and the attitudes they have towards receiving a PrEP recommendation from important people in their lives. This analysis is important because it highlights some of the social and psychological factors that inform the low uptake of PrEP among adolescent girls.

4.4.1 Subtheme 3.1: Adolescents' PrEP use and its perceived intended users

This study found that five of the 12 participants had never used PrEP before. While 18-year-old Dudu indicated that her reason for not using PrEP was a lack of interest, Grace reported:

> *"I have never used it in my life because I have never felt any need for it. I don't think I am at risk because I still use condoms"* (Grace, 18 years, August 2025).

Other participants echoed these sentiments, indicating that they had no liking for PrEP and did not believe they were at real risk of HIV infection. Although the findings indicate that these adolescent girls had never used PrEP because they did not find it necessary or appealing, it is interesting to note that the same participants were motivated by factors such as unprotected sex, age-disparate relationships, fear of sexual violence, and multiple sexual partners to initiate family planning. In accordance with the HBM, adolescent girls received cues to action from various information sources and perceived their vulnerability to pregnancy, the serious

consequences of becoming pregnant, and the perceived benefits of using family planning to prevent pregnancy. However, the same motivating factors could not influence adolescent girls to perceive their vulnerability to HIV, the seriousness of the disease, or the benefit of adopting PrEP to reduce the chances of acquiring HIV. Therefore, their attitude and belief may be that PrEP is irrelevant to them because they do not consider themselves vulnerable to HIV.

Conversely, other participants reported having used PrEP before but discontinued its use shortly after, except for Kabelo, who continues to use it. Consistent with other participants, Lerato said:

> *"Yes, I tried PrEP once for about a week but stopped because it made me feel very dizzy"* (Lerato, 19 years, July 2025).

Sharing similar experiences with side effects, Reena said:

> *"I stopped taking PrEP as soon as it started making me feel unwell. I wondered if the side effects would go away with time, but after three months of nausea, I just decided to stop on my own"* (Reena, 19 years, August 2025).

These narratives illustrate the recognition among adolescent girls of their vulnerability to HIV and their intentions to reduce the risk of infection by using PrEP. However, consistent with Adeagbo et al. (2025) and Chebet, McMahon, Tarumbiswa et al. (2023) the side effects of PrEP emerged as significant barriers to continued PrEP use in this study. Although some discontinued use earlier than others, their lack of confidence in being able to continue PrEP until the initial side effects subsided contributed to their defaulting. The intolerability of side effects led many adolescent girls in this study to believe that the associated suffering was unjustified, particularly when their perceived risk of HIV infection was low. This perception fostered discouragement and reduced motivation to continue using PrEP.

When discussing whom PrEP is intended for, all the participants agreed that it was meant for all HIV-negative individuals, including adolescent girls. For example, Kholu explained:

> *"... I believe PrEP is meant for anyone who wants to protect themselves from HIV"* (Kholu, 19 years, June 2025).

Similarly, other participants like Reena echoed:

"PrEP is meant for anyone who feels they might be exposed to HIV" (Reena, 19 years, August 2025).

These results indicate that the participants clearly understood whom PrEP is designed for: everyone at risk of HIV. While Western studies identify MSM as intended PrEP users (Chandler et al., 2022; Crooks et al., 2023; Gökengin, 2022), studies from sub-Saharan Africa report that men and women are often unsure about the intended users of PrEP; men believing it is for women, and women believing it is intended for men (Rousseau et al., 2021; Olugo et al., 2025). The findings of this study, however, reveal a strong awareness that PrEP is appropriate for anyone facing significant HIV risk. The participants in this study, contrary to adolescents in Europe and the USA, did not view PrEP as limited to key populations such as FSWs, MSM, or members of the lesbian, gay, bisexual, transgender, queer, intersex, and other (LGBTQI+) community (Hussein & Ferguson, 2019; Velloza et al., 2020). Instead, they recognised PrEP as intended for all people, including themselves, who may be vulnerable to HIV infection.

4.4.2 Subtheme 3.2: Narratives of adolescent girls regarding the impact of PrEP on sexual behaviour

This section discusses and analyses the findings on the opinions of adolescent girls regarding whether they believed the uptake of PrEP could influence or change the sexual behaviour of those who use it. The findings show that only Palesa, who was unfamiliar with PrEP, was unsure how PrEP could affect adolescent girls' sexual behaviours. Four participants, namely Praise, Kabelo, Grace, and Mapule, did not believe PrEP could influence adolescent girls to engage in risky sexual behaviours. For instance, Kabelo said:

"Mmm... no, I don't think PrEP causes risky behaviour. It depends on the person. If someone is already engaging in sex with multiple partners, they will continue, but PrEP itself doesn't make them behave that way" (Kabelo, 19 years, July 2025).

This perspective was shared by all four participants, who dismissed the notion that PrEP promotes risky sexual behaviour. They argued that personal character traits shape an individual's behaviour rather than PrEP use. They thus rejected the idea that PrEP itself is a driver of behaviour among adolescent girls. Consequently, this view does not indicate any negative attitudes towards PrEP. They did not associate the use of PrEP with the user's sexual behaviour and therefore did not harbour stigmatising views about PrEP. In contrast, seven participants believed that PrEP use affected the sexual behaviour of adolescent girls. Most shared Lethabo's view:

> *"Yes, I think that it can affect how they behave. I think an adolescent would assume that since she is protected [from HIV], she would engage in everything freely, or loosely, without taking caution"* (Lethabo, 19 years, July 2025).

Reena raised an important point that adolescent girls may engage in even riskier sexual behaviour, particularly when they know they have taken steps to prevent pregnancy. Consistent with this view, Reteng said:

> *"I think it might [affect sexual behaviour], because a person may feel they don't fear anything because they will be using FP for preventing pregnancy and PrEP for HIV. So, it is possible that a person may not think about protecting themselves"* (Reteng, 19 years, August 2025).

These narratives indicate that some adolescent girls believe that using PrEP can lead to risky sexual behaviour, with significant concerns about risk compensation, where feeling protected from HIV or pregnancy might reduce caution. In line with evidence from the USA indicating a positive association between PrEP use and increased STI incidence (Storholm et al., 2017; Williams et al., 2022), this study similarly observed an association between PrEP use and engagement in risky sexual behaviours. The participants indicated that people can be careless when they know that PrEP will protect them from HIV. This perceived link between PrEP and the intentional engagement in risky sexual behaviour might also cause potential users to fear being seen as sexually careless. Additionally, it could lead healthcare providers to gatekeep PrEP access, believing it lowers inhibitions in adolescents. Geldsetzer et al. (2022) also found that healthcare providers were reluctant to provide PrEP to adolescents because they believe it promotes sexual immorality.

Although a few participants believed that using PrEP does not alter adolescents' sexual behaviours, the majority believed that it has an impact on sexual behaviours. They believed that PrEP lowers inhibitions and encourages users to engage in unsafe sexual relations with multiple partners because they think they are protected. These views are inherently stigmatising, and even when stigma is not externally imposed, its internalisation may constrain adolescent girls who hold such views from initiating or continuing PrEP use due to fears of being perceived as having low inhibitions. Such beliefs and attitudes exert an inhibiting influence that may further discourage adolescent girls from using or sustaining PrEP, driven by concerns about being labelled as promiscuous. To explore this further, the next section

examines whether, because of these beliefs and attitudes, adolescent girls who are not taking PrEP would consider using it if it were recommended to them.

4.4.3 Subtheme 3.3: Between recommendation and choice: Adolescent girls' engagement with PrEP prescriptions

The analysis of whether adolescent girls would consider PrEP if it were recommended to them – regardless of whether they had previously used it and stopped, or had never used it at all – is important. Initially, the discussion focuses on PrEP recommendations in general terms, whether made by healthcare providers, peers, or, in other cases, partners. The discussion then explores adolescents' willingness to take up PrEP when recommended by important or influential people in their lives, such as religious leaders, celebrities, or others they consider significant.

Apart from Kabelo, who was using PrEP at the time of the interviews, only Grace, who had never used PrEP before, and Praise, who discontinued PrEP use, expressed willingness to consider PrEP if it were recommended to them. Grace stated:

> *"Well, yes, I wouldn't mind using it because I think it helps in reducing the risk of HIV infection for us young girls in sexual relationships with more than one guy"* (Grace, 18 years, August 2025).

Her comments reveal an awareness of the vulnerabilities faced by adolescent girls, such as engaging in multiple sexual partnerships, and an understanding of PrEP's potential to lower HIV risk. For both Grace and Praise, receiving a PrEP recommendation might signify social acceptance and normalisation of PrEP use among girls their age, thus making them more receptive to taking it when advised.

In contrast, nine participants expressed reluctance to adopt PrEP when it was recommended to them. Several reasons were given for their reluctance, with Dudu stating she would not take PrEP even if her own mother or boyfriend thought she should. This resoluteness was common among the participants, which stemmed from fear of judgement for using PrEP, dislike or fear of experiencing side effects, PrEP fatigue, and the conflation of PrEP with ARVs.

For instance, Kholu explained:

> *"The truth is, it scares me. I don't trust it enough to feel comfortable having it in my body because after asking around, I heard that PrEP is actually ARVs, and that really worried me"* (Kholu, 19 years, June 2025).

Similarly, demonstrating an unwillingness to use PrEP, Reteng was even willing to accept an HIV-positive status rather than take PrEP. She exclaimed:

> *"Well, honestly, [laughs] I don't think it's something I can go back to using. I guess I will have to accept and come to terms with the fact that I might have to initiate ART; it doesn't matter, because after all, it's one and the same thing"* (Reteng, 19 years, August 2025).

These narratives demonstrate how deeply entrenched negative perceptions undermine PrEP uptake, even among adolescent girls who recognise their vulnerability to HIV infection. This study found that resistance to PrEP is driven by fear of stigma, conflating PrEP with ART, concerns about side effects, and fatigue associated with taking pills daily, as seen in other international studies (Rousseau et al., 2021; Muhumuza et al., 2021; Olugo et al., 2025). Believing that PrEP and ART are the same is problematic because it reinforces misinformation and increases stigma, thereby causing delays in seeking appropriate care, as individuals may not seek or adhere to PrEP. The willingness of some participants to risk HIV acquisition rather than initiate PrEP highlights the intensity of these perceptions and demonstrates how PrEP-related stigma and distrust shape health-related behaviours. Notably, Reteng acknowledged inconsistent condom use due to her partners' refusal, which increased her exposure to HIV. Despite this elevated risk, Reteng expressed reluctance to use PrEP, indicating a preference to avoid PrEP until HIV seroconversion, at which point she believed treatment would be necessary. She insisted that she would rather use ARVs than PrEP. This decision indicates inadequate knowledge of PrEP among adolescent girls and raises critical questions about the credibility, accessibility, and sources of information adolescents rely on to inform their SRH decision making, as cautioned by Kalula et al. (2023) and Garett and Young (2022).

Apart from Grace and Praise, who both said that if PrEP were recommended to them, they would be willing to take it, only Lethabo indicated willingness to consider using it again, only if strong circumstances convinced her that it was truly necessary, especially when it is recommended by salient others.

She said:

> *"I think I would consider taking it, especially if there were compelling reasons for me to, like if I learned of my partner's new HIV status. But it would take some convincing first"* (Lethabo, 19 years, July 2025).

Lethabo's inclination to consider using PrEP when advised by someone she trusts, particularly following a partner's changed HIV status, shows that influential people can shape PrEP behaviour. To a certain degree, an adolescent girl might see this recommendation as a sign of approval and acceptance of PrEP use, which could help to reduce the stigma associated with it.

On the contrary, the other participants maintained their reluctance to start using PrEP, even when highly significant or influential people in their lives endorsed it. Reteng explained:

> *"[Laughing] Honestly, I don't even want to lie to you, I would not agree. It would not make a difference who talks to me. My mind is made up"* (Reteng, 19 years, August 2025).

This narrative reflects firmness in the decision not to use PrEP. To say *"My mind is made up"* signals resistance to persuasion and asserts that Reteng's decision was final and not open to persuasion. Having used PrEP before, Reteng might have suffered traumatic experiences, which contributed to her PrEP resistance. Moreover, this attitude might also stem from limited information, internalised stigma, or power imbalances in her relationships that shaped her beliefs.

This study supports the findings of Alio et al. (2019) and Kgatle (2019) by revealing that Lerato and Kholu, in concurrence with the other participants, argued that the pill burden and religious beliefs are major barriers to taking PrEP, even when key figures recommend it. Many were not eager to take pills daily, perceiving the routine as tiresome if they were at risk of HIV. Consequently, adolescent girls are unlikely to follow PrEP advice, as they already doubt their ability to adhere, which aligns with the TPB concept of self-efficacy. The framework suggests that low self-efficacy reduces the likelihood of adopting or maintaining behaviour because of doubts about one's capacity. Furthermore, religious beliefs, such as those of the Catholic Church, oppose using PrEP outside marriage because it rejects contraceptives and HIV prevention methods that do not involve abstinence, with the aim of avoiding supporting what it considers immoral activity (Catholic Medical Association, 2021). The reluctance to use PrEP,

even when recommended by salient others, might therefore be influenced by a combination of factors that need to be identified and effectively addressed.

For other participants like Mosa, the fear of stigma continues to be a major obstacle, regardless of who recommends PrEP, similar to the findings by Obeagu and Obeagu (2024). The fear of what people would say prevented many participants from taking up PrEP.

Mosa stated:

> *"Still, I wouldn't feel comfortable using it, so no. There's a lot of stigma out there. Umm... People confuse it with ARVs, and I'm not ready for people to think that I'm HIV positive, you know? Also, if I took it, I'd have to explain to my boyfriend why I'm taking PrEP, and he might think I'm being unfaithful or hiding something"* (Mosa, 19 years, June 2025).

The narrative demonstrates how stigma and relationship dynamics act as significant barriers to PrEP use, even when recommended by influential people. Fear of being perceived as HIV positive discourages uptake, which illustrates how misinformation fuels stigma. Additionally, concerns about their partners' reactions reflect trust and communication challenges, where taking PrEP may be interpreted as infidelity rather than prevention. Similarly, participants in a Kenyan study declined PrEP because they feared their partners would leave them (Olugo et al., 2025). Overall, perceived judgement outweighs perceived health benefits, thus limiting the willingness to use PrEP despite its protective value.

In summary, the findings demonstrate that PrEP recommendations alone, whether from healthcare providers, peers, family members, or influential figures, were insufficient to influence the adolescent girls in this study to adopt or reinitiate PrEP. For some participants, it would require a combination of PrEP recommendations and a partner's HIV seroconversion for them to consider PrEP. Only Grace, Praise, and Lethabo showed willingness to take up PrEP when it was recommended to them by people whose opinions they valued. This indicates a belief in the acceptance and approval of PrEP use in their social network. However, most participants remained resistant. This reluctance was driven by compounding factors such as stigma, misinformation, fear of judgement, pill burden, relationship dynamics, and prior negative experiences with PrEP. For many, the association of PrEP with ART created a powerful barrier, which overshadowed its preventive benefits and reinforced perceptions that PrEP use invites social scrutiny or suspicions of HIV positivity or infidelity. Ultimately, these

findings highlight the need for more nuanced, stigma-sensitive, and adolescent-focused approaches to PrEP communication and education. Without addressing entrenched fears, misinformation, and building trust in PrEP's purpose and safety, recommendations, even from highly valued individuals, are likely to remain insufficient to change behaviours among adolescent girls who navigate significant social constraints.

4.5 Theme 4: The impact of stigma on the uptake of PrEP among adolescent girls

This theme highlights the role of stigma in shaping the uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho. In Section 4.4, the findings of this study indicated that fear of stigma is a major social barrier that discourages many adolescent girls from initiating or continuing PrEP as a means of preventing HIV infection. This section therefore examines how adolescent girls understand, interpret, and navigate stigma in their own experiences. The discussion begins by exploring the perceived acceptability of PrEP use among adolescent girls, community perceptions towards the use of PrEP by adolescent girls, adolescents' expectations of how others might react to their PrEP use, and how stigma emerges from these. Undertaking this analysis was critical for determining whether these fears stem from actual experiences of stigma or from internalised perceptions of it.

4.5.1 Subtheme 4.1: Narratives of adolescent girls about the acceptability of using PrEP

Building on the earlier discussion about who adolescent girls considered to be the intended users of PrEP, the participants were asked whether they believed it was appropriate for adolescent girls to use it. All the participants, except Dudu, shared the view that it was acceptable for adolescent girls to use PrEP if they felt the need to. Kabelo and Reteng explained:

> *"I feel like it is right because girls encounter so many challenges in relationships and life in general. They get into relationships with older men, their boyfriends cheat on them with many girls and refuse to use condoms, they fall victim to sexual abuse, and so many other challenges. Oh, also, they want to try this and that so PrEP can help protect them"* (Kabelo, 19 years, July 2025).

> *"I see it as a good thing for them to use. Well, as Ma2000 [millennials] we love groove [partying]. So, when we're out partying the night away, and you are at a point where*

> *you are now drunk, you lose control of yourself and all inhibitions, and you end up with this guy and that one. So, it is going to be painful at the end of the day when you find out you are HIV positive and don't know who infected you"* (Reteng, 19 years, August 2025).

These narratives demonstrate a clear awareness of some of the social factors that increase their vulnerability to HIV, which justifies the acceptability of PrEP among adolescent girls. These narratives highlight a clear recognition of risks rooted in unequal power relations with older partners, partners' inconsistent use of condoms, exposure to sexual violence, and the influence of alcohol and nightlife on decision making. By explicitly linking these contextual vulnerabilities to the potential protective value of PrEP, the participants framed PrEP not as an admission of promiscuity but as a practical response to the social risks they perceived as unavoidable and prevalent in their lives. This awareness also suggests that adolescent girls view PrEP as an empowering tool that offers control in situations where their control is often limited, which reinforces its appropriateness and acceptability in their social realities.

In contrast, Dudu viewed PrEP use among adolescent girls as inappropriate, despite recognising the same factors that make these girls vulnerable to HIV. She argued that PrEP itself fosters this vulnerability by giving girls a false sense of security that they can engage in risky sexual activities, believing they are protected from HIV. She stated:

> *"I honestly feel like it is not good for them. I hate the fact that when a person uses it, they may feel like they can go gallivanting around without any care in the world"* (Dudu, 18 years, August 2025).

This narrative reflects an attitude towards PrEP based on its perceived impact on the sexual behaviour of its users. From Dudu's perspective, the very factors that other participants referenced as reasons why adolescent girls need PrEP are, in fact, the risky, compensatory behaviours that girls engage in as a consequence of using PrEP, which suggests that these behaviours could be avoided if they did not use PrEP.

These findings illustrate the complexity surrounding perceptions of PrEP use among adolescent girls. While most participants recognised PrEP as a necessary and empowering strategy in contexts where social factors heighten their vulnerability to HIV, Dudu interpreted the same circumstances as evidence that PrEP might unintentionally encourage risky sexual behaviour. The contrasting narratives emphasise the importance of addressing not only the social drivers

of HIV but also the social meanings attached to prevention strategies such as PrEP. These meanings may, in turn, encourage or discourage adolescent girls from using PrEP. However, these narratives demonstrate that adolescent girls consider the use of PrEP as appropriate and acceptable, even though they themselves did not use it. This directly contradicts their earlier claims of fearing PrEP-related stigma, as mentioned in Sections 4.3 and 4.4, where they expressed hesitation to use PrEP because it was seemingly not accepted and that people using it were labelled as having low sexual inhibitions. The participants seemed to view PrEP positively when considering other adolescent girls, but quickly assumed a negative attitude when it came to themselves, almost as if it was wrong for them to use it relative to others.

4.5.2 Subtheme 4.2: Societal pressures that affect the uptake of PrEP among adolescent girls

Continuing the discussion on community perceptions of PrEP, this section examines how adolescent girls believe their communities view girls who use PrEP. This assessment is essential for determining whether a lack of interest in PrEP among adolescent girls stems from their perceptions of community attitudes towards PrEP use. Mindful that some participants had never used PrEP, they were asked whether people's opinions about their PrEP uptake or use mattered; almost all the participants, except Dudu and Kholu, said it did not. They explained that even if others expressed upsetting views, it would not affect their decision to take up or continue taking PrEP. They acknowledged that people might talk or judge, but stated they would not be deterred by such comments. The other participants agreed with Lethabo, who stated:

> *"[W]hatever other people say shouldn't matter really. In fact, instead of being discouraged, I'd rather take it secretly without anyone knowing or even noticing"* (Lethabo, 19 years, July 2025).

In the same light, Lerato added:

> *"I don't think stigma is a big issue anymore. Nowadays, people living with HIV are generally accepted, and we share things with them except where transmission is possible. Since I know PrEP will benefit me, I don't mind what others think or say"* (Lerato, 19 years, July 2025).

Ten participants reported that other people's opinions about their PrEP use held little influence over their PrEP decisions. Despite acknowledging the possibility of judgement or stigma, they emphasised personal motivation, health priorities, and a strong sense of autonomy. For many, potential stigma was not a deterrent but rather a factor that might influence how they took PrEP, such as discreetly in the case of Lethabo. These findings reveal a discrepancy: some participants reported that they would prefer to continue using PrEP in secret rather than to stop using it, while the majority had already discontinued its use and chose not to use it covertly. Additionally, these findings highlight contradictions in the participants' fears of PrEP-related stigma when explaining why they did not use PrEP, alongside their claim that the stigmatising opinions people have about their potential PrEP use were irrelevant. They asserted immunity from judgement but expressed fear of facing the same judgement when justifying not using PrEP. These contradictions reveal long-standing internalised and socialised stigmas and may also indicate an unconscious acknowledgement of judgemental attitudes that the participants had towards PrEP users, which they feared could be directed at them too. These narratives indicate that, although social judgement is recognised, it is no longer perceived as a significant barrier to PrEP uptake, which contradicts existing literature (Chittamuru et al., 2020; Obeagu & Obeagu, 2024; Olugo et al., 2025). This reflects a broader shift towards reduced stigma and the normalisation of PrEP, as illustrated by Lerato's statement that people living with HIV are now generally more accepted than they were in the past.

In contrast, Kholu and Dudu indicated that the opinions of other people regarding their PrEP use were an important factor, as these views may affect how they engaged with PrEP. For instance, Kholu mentioned:

> *"Wow... the judgement out there is intense! People judge you so harshly, and it's really unsettling"* (Kholu, 19 years, June 2025).

Similarly, Dudu added:

> *"Yes, I think it matters what people say or think, because they can negatively influence a person's behaviour, especially those with a low sense of self-confidence. A person can end up defaulting on their medication, even when they themselves see the importance of the medication in their lives, but because people are talking, they end up stopping"* (Dudu, 18 years, August 2025).

Congruent with existing literature (Rousseau et al., 2021; Muhumuza et al., 2021; Stoebenau et al., 2024; Velloza et al., 2020), these findings illustrate how social judgement can directly undermine PrEP uptake and adherence by shaping an individual's sense of safety, confidence, and self-worth. Kholu's description of intense public judgement highlights how stigma creates an environment in which taking PrEP becomes risky, which can prompt fears of being labelled or judged. Dudu further clarified the behavioural consequences of such pressures, noting that negative opinions from peers or community members can erode self-confidence and ultimately lead individuals to discontinue PrEP, even when they recognise its health benefits. These accounts show that the opinions of others do not simply influence attitudes; they can actively disrupt consistent PrEP use, which renders stigma a critical barrier to sustained PrEP engagement.

Nonetheless, the findings indicate that every participant expected to receive negative remarks about their PrEP use, regardless of whether it actually affected their behaviour. When asked how they thought others would react to their PrEP use, the participants mentioned expecting significant judgement from their peers. Most participants agreed with Mosa's statement:

> *"Of course, people will judge. They might assume my partner is HIV positive or think I'm being unfaithful to him"* (Mosa, 19 years, June 2025).

Fearing moral judgement against PrEP use as well, Lethabo added:

> *"They would ridicule me, especially because back home in the rural areas where I come from, there is still that stigma and perception that some things are inappropriate, whereas they are just a means of protection. You are perceived as a morally loose person and you are viewed in a certain negative way"* (Lethabo, 19 years, July 2024).

These narratives reflect how anticipated stigma, rather than actual experiences, shaped the participants' perceptions of how others might react to their PrEP use. These insights frame PrEP-related judgement not as an isolated concern but as embedded in broader social norms that conflate HIV prevention with infidelity, immorality, or "loose" behaviour. They further illustrate how cultural and community contexts, particularly in rural settings with entrenched moral codes, amplify fears of scrutiny and gossip. However, the findings also reveal a distinction between anticipated and actual stigma: the participants assumed negative reactions even when no concrete incidents occurred.

While most participants were not using PrEP, they explained that they would not disclose their use of it to anyone if they were to start. This is due to the potential stigma they might encounter.

Like many participants who would not be willing to speak openly about their PrEP use, Grace shared the following:

> *"I wouldn't tell anyone. Look, since it is a private matter, and my secret alone, I don't think I could tell anyone, not even my friend. I just wouldn't want people to know, that's all, because they assume a lot"* (Grace, 18 years, August 2025).

Similarly, Lethabo also added:

> *"No, I wouldn't want anyone to know. It would be something I keep to myself because I don't want judgement, as if I am a promiscuous person"* (Lethabo, 19 years, July 2025).

Even Kabelo, who continued to use PrEP, preferred not to divulge her PrEP use to others, as she valued confidentiality rather than fearing judgement. In contrast, Dudu would choose not to disclose her PrEP use because she wanted her boyfriends to continue taking preventive measures against HIV. She stated:

> *"I wouldn't tell my boyfriends. Boys are very silly and devious in nature. So, I can't say anything so that whatever they do, they still take caution"* (Dudu, 18 years, August 2025).

These findings reveal an interplay between privacy, fear of stigma, and strategic non-disclosure in the participants' decisions not to disclose their PrEP use, should they choose to use it. While most participants described non-disclosure as a way to avoid moral judgement, particularly stereotypes of promiscuity, these perspectives also highlight how PrEP use is embedded in broader social dynamics as a marker of trust, gendered expectations, and perceived reflections of sexual behaviour. Importantly, reluctance to disclose is not solely rooted in fear or shame. For participants like Kabelo, it reflects a desire for personal autonomy, whereas for others like Dudu, non-disclosure is a deliberate tactic to ensure that partners do not engage in risky sexual behaviours. The findings show that non-disclosure is not merely evidence of stigma but, at times, a strategy for maintaining privacy.

4.5.3 Subtheme 4.3: Encounters of PrEP-related stigma among adolescent girls

This section analyses real-life experiences of PrEP-related stigma encountered by adolescent girls. Sections 4.3 and 4.4 identified stigma and the fear of it as significant barriers to PrEP uptake and adherence among adolescents. When assessing reports of judgement or unfair treatment related to adolescents' PrEP use, the findings indicated that none of the participants, either personally or through others, reported experiencing stigma. Mosa explained:

> *"No, I haven't experienced any. Uhm... I don't know if it's because people are just not talking about it or if it's not happening"* (Mosa, 19 years, June 2025).

Likewise, Lethabo echoed:

> *"Well, I don't know of a specific person, but you'd hear judgement in the way those people are viewed in society"* (Lethabo, 19 years, July 2025).

These findings reveal no known actual experiences of stigma due to PrEP use. They contradict existing literature on people being subjected to stigma for using PrEP by families and communities (Olugo et al., 2025; Velloza et al., 2020; Chittamuru et al., 2020).

This study uncovered that the participants have internalised stigma to the extent that, even in the absence of a specific incident they could identify, they anticipated judgement for using PrEP. Kholu stated:

> *"No, I don't personally know anyone using PrEP or ARVs, but when I look at how society treats people living with HIV, it's heartbreaking. It's often said that things are different now, but the way I see things, the stigma is still there. People still look at you in a certain way, especially if they see you going to collect your ARVs, without even knowing what that person has been through or how they got infected*" (Kholu, 19 years, June 2025).

This finding presents an important picture: while adolescent girls consistently identified stigma as a major barrier to PrEP uptake, none of the participants reported direct or observed experiences of PrEP-related stigma. This discrepancy suggests that the perception of stigma may be shaped more by broader societal attitudes towards HIV and ARV use than by concrete incidents related to PrEP itself. The uncertainty about whether stigma is absent or simply unspoken, along with Lethabo's reference to "judgement" embedded in societal views, indicates anticipated stigma rather than lived experiences of stigma. Kholu's reflection further

highlights this point, as her concerns stemmed from the ongoing, visible marginalisation of people living with HIV, which she perceived as transferable to PrEP users due to the association with ARVs. Overall, the absence of a direct narrative of PrEP-related stigma highlights that PrEP uptake was low among the adolescent girls in this study because they feared the stigma that they might face for using PrEP.

In summary, the findings reveal that most adolescent girls in this study considered PrEP appropriate and empowering, recognising that unequal relationships with older partners, inconsistent condom use, exposure to sexual violence, and alcohol-related loss of control heightened their vulnerability to HIV. For these participants, PrEP was seen as a practical tool for protection rather than a marker of promiscuity. Only Dudu opposed PrEP use among adolescent girls, arguing that it encourages risky behaviour by creating a false sense of security. While most girls said they would use PrEP regardless of other people's opinions, they also anticipated judgement, especially associations with infidelity or moral looseness, which would motivate them to keep their PrEP use private. A minority, including Dudu and Kholu, felt that community opinions could undermine confidence and lead to discontinuation. Despite widespread expectations of stigma, none of the participants reported direct experiences of PrEP-related stigma. Instead, their fears stemmed from broader societal stigma surrounding HIV and ARVs. Overall, the findings show that adolescent girls generally perceive PrEP as acceptable and protective, but anticipated stigma and moral judgement strongly shape disclosure practices and may influence uptake. In contrast, existing literature demonstrates that in some communities, PrEP is understood as a prevention strategy primarily for FSWs and MSM. This perception undermines its acceptability among the general population (Hussein & Ferguson, 2019; Velloza et al., 2020).

4.6 Theme 5: How accessible PrEP is to adolescent girls in Berea

This section presents the findings of the study on how accessible and available PrEP is to adolescent girls in Berea, Lesotho. Although availability and accessibility are primarily structural issues, the research focused on their social dimensions, specifically whether parental authority and societal expectations, which often hinder use among adolescent girls, influenced their ability to access PrEP.

Apart from Palesa, who previously mentioned a lack of PrEP awareness, all the participants knew where to access PrEP in their communities. Many were aware that they could receive

similar services at their local health facilities but preferred the CoHiP SEC centres, which were often within walking distance. However, for participants such as Mosa, Kholu, Palesa, Lethabo, and Reena, the facilities were far and required transport. To obtain transportation money, they often had to ask their parents and risk inadvertently revealing their use of family planning services and PrEP while explaining what the money was for and where they were going. For example, Kholu said:

> *"Given the kind of family I come from, Jo! I wouldn't want anyone to know. The clinic is a bit of a distance but a distance I can walk to avoid telling my mom"* (Kholu, 19 years, June 2025).

This illustrates how fear of parental disapproval can hinder adolescent girls from accessing PrEP. While Kholu would rather walk than risk unintentional disclosure, others might be discouraged from starting these services due to concerns about sustainability and adherence, given the distance to the clinics.

In contrast, other participants were open with their parents about their use of SRH services and, as a result, did not fear parental reprimand or societal pressure. For participants like Reena, Dudu, and Reteng, their parents knew about their use of SRH services, and they preferred it that way because they were then given support to access such services. Reena explained:

> *"I only told very close people like my partner and family, so that they aren't surprised by the routine trips to the clinic, or the medication I take all the time or the many pills in my room. They should know why I take them so that they let me go freely"* (Reena, 19 years, August 2025).

While other studies report a lack of support from important people for PrEP users, which often led to PrEP discontinuation (Mwakilasa et al., 2025; Mudzingwa et al., 2024; Rousseau et al., 2021), the findings of this study demonstrate that support from close family members and romantic partners facilitates access to SRH services and PrEP. For several participants, the distance to facilities created not only financial barriers but also the risk of unintentionally revealing their use of family planning services or PrEP, which prompted some, like Kholu, to walk long distances to avoid parental scrutiny. This highlights how fear of parental disapproval can hinder or delay PrEP uptake and adherence, even when services are geographically within reach. In contrast, those participants who had open communication and support from their parents experienced fewer barriers in accessing services routinely. Overall, the findings

demonstrate that family support and reduced stigma are critical facilitators of adolescents' access to PrEP and SRH services.

Since this study focused on adolescent girls who were already using family planning services, it was important to determine whether they knew that PrEP was also offered at the same facilities where they obtained their contraceptives, so that the question of access and availability could be explored as a potential barrier to PrEP for these participants. Most participants, except Palesa, were aware of the integration of PrEP into family planning services despite the low PrEP uptake. Palesa said:

> *"No, I had never heard about PrEP before. I honestly don't know what it is. Even though I've come here for family planning services, no one has ever talked to me about PrEP"* (Palesa, 18 years, July 2025).

However, the other participants knew that they could also access PrEP during their family planning clinic visits. This finding validates the exploration of other factors, particularly social, to determine why the uptake of PrEP is low among adolescent girls who use contraceptives.

Overall, the findings indicate that while PrEP was generally available for free and geographically accessible to most adolescent girls, access alone did not translate into higher PrEP uptake. For many participants, the need to travel long distances or request money to do so risked exposing their use of PrEP to their parents, which reinforced fears of parental disapproval and discouraged initiation or consistent use. In contrast, girls who had open communication and support from their parents experienced fewer access-related barriers and were better able to engage with SRH services routinely. The study therefore demonstrates that although structural access to PrEP exist, social factors, such as family dynamics, stigma, and the fear of unintended disclosure, play a more decisive role in shaping PrEP uptake among adolescent girls in Berea.

4.7 Discussion of the findings

In this study, semi-structured interviews helped to uncover several social factors that discourage adolescent girls who use family planning services from using PrEP. These include internalised fear of PrEP-related stigma, lack of familial support, the conflation of PrEP with ARVs, PrEP fatigue, and the lack of perceived HIV risk. These factors are perceived to inform adolescents' decisions to decline taking up PrEP or discontinue its use while still being very

much vulnerable to HIV infection. One of the key findings of this study is that although adolescent girls widely fear stigma associated with PrEP use, neither the participants nor the people they know have actually experienced such stigma. Rather, this fear stems from internalised stigma, which leads them to anticipate judgement if they were to use PrEP. Chapter 1 outlined numerous government efforts and policy actions intended to enhance PrEP uptake among young people. However, this study demonstrates that the social realities of adolescent girls do not fully align with the policies established for young people. Legally, adolescent girls are entitled to access health services; however, social challenges beyond the scope of the law hinder their ability to utilise available SRH services.

The findings of this study demonstrate that adolescent girls in Berea use various sources of information to learn about family planning services and PrEP, including the Internet, print media, and outreach campaigns. The findings indicate that the participants' fear of unintended pregnancies was based on engaging in risky sexual activities with multiple, sometimes older, partners. Some participants were motivated by fear of sexual violence in their communities to use family planning. Inadvertently, these reasons for using family planning also put adolescent girls at risk of HIV. These findings are supported by Murewanhema et al.'s (2022) study, which reports that factors such as alcohol and drug use, multiple concurrent relationships, inconsistent condom use, and a history of intimate partner violence increase HIV risk among adolescent girls in sub-Saharan Africa. In contrast, a cross-sectional study in Europe found that adolescent girls used family planning mainly to regulate their menstruation and reduce acne (European Parliamentary Forum, 2022; Ti et al., 2022). This study therefore suggests that the same factors that influence family planning use expose adolescent girls to HIV, creating a potential need for PrEP, which is underused.

Although seven of the 12 adolescent girls who participated in this study had used PrEP before, the findings indicate that six had stopped using it, leaving only one girl using it at the time of the interviews. This low uptake aligns with other research in sub-Saharan Africa, which shows that PrEP usage remains low among adolescent girls (Murewanhema et al., 2022; Admassu et al., 2024; Chen-Charles et al., 2025). The findings indicate that many girls did not see themselves as vulnerable to HIV despite their sexual behaviours, which included inconsistent condom use and having multiple partners, which increased their risk and led them to family planning. The participants' low perception of risk led them to believe that PrEP was unnecessary and irrelevant, as also found in global literature on adolescents who seldom use PrEP (Ogello et al., 2024; To & Lee, 2018; Lau et al., 2020; Admassu et al., 2024; Kayesu

et al., 2022). While some participants had never used PrEP before, others stopped shortly after starting, which demonstrates low motivation to translate risk awareness into action.

The study also found that although many participants feared stigma, none reported personal experiences of stigma due to PrEP use or knew anyone who had been stigmatised. This finding does not support the existing literature, which identifies widespread stigma towards people who use PrEP (Adeagbo et al., 2025; Kamitani et al., 2024). However, the participants expressed concerns about people conflating PrEP and ARVs, which would lead many to assume the participants were HIV positive for using PrEP. The participants also feared being perceived as promiscuous or morally loose, especially in rural areas where gossip spreads quickly. These findings align with a Malawian study on factors that affect PrEP use, which found that anticipated stigma and fear of being perceived as promiscuous or HIV positive significantly hindered adolescent girls from starting or continuing with PrEP (Nicholas et al., 2025). Most importantly, this study highlights that whether stigma is real or anticipated, it acts as a barrier that discourages adolescent girls from using PrEP.

A study conducted in Denmark among MSM found a considerable decline in condom use and an increase in STI incidences since PrEP was introduced (Von Schreeb et al., 2024). A study conducted in Wales reported similar concerns about reduced condom use among MSM using PrEP, as PrEP was perceived to lessen fears of HIV acquisition (Williams et al., 2022). Similarly, the findings of this study indicate that the participants perceived PrEP use among adolescent girls as potentially encouraging engagement in risky sexual behaviours, based on the belief that PrEP provides comprehensive protection. While it might be assumed that such perceptions of comprehensive protection would increase PrEP uptake among young people, especially because they already use condoms inconsistently, uptake remains low.

While studies in Asia and sub-Saharan Africa found pill burden to be a major barrier to PrEP uptake (Rungmaitree et al., 2024; Muhumuza et al., 2021), a US-based study identified the issue not as the daily pill burden but as concerns about the long-term effects of taking pills every day (Dave, 2024). This study likewise found that PrEP was viewed as burdensome due to its daily dosing, which would make long-term adherence particularly challenging in environments with limited privacy. Beyond the pill burden, many participants were unsure about what to do if they missed a dose and unclear about how long they needed to take PrEP to achieve optimal protection. This uncertainty could potentially expose them to HIV infection, as they might believe that they are protected when they are not, due to incorrect use. Similar to

the findings by Muhumuza et al. (2021), the findings show that some girls ceased using PrEP simply because they could not cope with the daily routine.

While support from healthcare providers and significant others was expected to positively influence PrEP uptake, the findings show that such endorsements alone were insufficient. Most participants expressed reluctance to use PrEP even when encouraged by parents, partners, pastors, and community leaders. This contrasts with literature emphasising the importance of normative approval for shaping adolescent sexual health behaviours (Haribhai et al., 2023). In this study, deeply rooted fears, particularly around stigma and associations with HIV treatment, overpowered the influence of recommendations. Only a small minority interpreted such encouragements as signs of safety and acceptance. This demonstrates how deeply ingrained misperceptions and stigma can neutralise otherwise positive social influences.

The literature suggests that physical availability and service integration do not always ensure PrEP uptake (Nonyana et al., 2022; Rousseau et al., 2024). Similarly, the findings from this study demonstrate that although PrEP was largely accessible and geographically within reach for participants in Berea, its uptake was more deterred by social factors than by structural ones. Most participants knew where to obtain PrEP, which was often at the same clinics where they accessed family planning services. However, fear of parental disapproval, concerns about unintended disclosure, and broader societal expectations influenced whether they accessed these services and how. For girls like Kholu and others who live far from clinics, requesting transport money risked revealing their PrEP use, leading some to walk long distances or avoid services altogether, which hindered initiation and adherence despite physical availability. In contrast, girls whose parents were supportive and well informed had more regular access to SRH services compared to those who lacked support.

4.8 Conclusion

This chapter began by presenting the study's findings on adolescent girls' use of family planning. The chapter identified family planning information sources and discussed the reasons adolescent girls use family planning. Key among these reasons was the need to prevent unwanted pregnancies, which could result from inconsistent condom use, partners' refusal to use condoms, and sexual violence. Recognising that the risk factors that led adolescent girls to use family planning unintentionally exposed them to the risk of HIV infection, the chapter then presented adolescents' knowledge around PrEP. The study found that only one participant out

of 12 did not know anything about PrEP. The findings further indicated that while five participants had never used PrEP, only one participant continued using PrEP of the six who discontinued PrEP use shortly after initiation. The reasons given for the refusal and the discontinuation of PrEP included fear of stigma, lack of perceived risk, side effects, and the pill burden. Furthermore, issues relating to the stigma associated with PrEP were discussed, with the findings demonstrating that the participants feared anticipated stigma, which was internalised through social interactions. The chapter ended with a discussion of the findings, which compared and contrasted them with existing literature.

The next chapter presents a summary of the findings and makes recommendations for future research.

CHAPTER 5:
SUMMARY OF FINDINGS, RECOMMENDATIONS, AND CONCLUDING REMARKS

5.1 Introduction

This final chapter provides a holistic overview of this research inquiry into the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho. It outlines and summarises the key findings of the study, which were presented, analysed, and discussed in Chapter 4. The summary is organised thematically in accordance with the research questions. Following this summary, the chapter discusses the contributions the study makes to existing knowledge concerning adolescent girls' sexual health in Lesotho. Subsequently, it outlines key recommendations to inform future research and for healthcare service providers. The chapter concludes by sharing the study's limitations and the researcher's concluding remarks. Since the study focused on adolescent girls using family planning services, it was essential to determine how their use of these services might have exposed them to the risk of HIV. Accordingly, the summary of the key findings begins by outlining and synthesising the main factors that led adolescent girls to utilise family planning, which might inadvertently expose them to HIV.

5.2 Summary of key findings

This section discusses how the study addressed the main research question, namely "What are the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho?" To effectively address this question, the analysis revealed the following themes in response to the research sub-questions:

- Narratives of Basotho adolescent girls concerning family planning use;
- Adolescent girls' knowledge about PrEP in Berea;
- Social and psychological factors that affect PrEP uptake among adolescent girls;
- The impact of stigma on the uptake of PrEP among adolescent girls; and
- How accessible PrEP is to adolescent girls in Berea.

5.2.1 Theme 1: Narratives of Basotho adolescent girls concerning family planning use

Chapter 4 began with an introductory theme that linked the use of family planning services to PrEP. The study uncovered that many adolescent girls who participated in the study were in age-disparate relationships and had multiple sexual partners. Although the pregnancy risk factors varied among the participants, they all wanted to prevent the likelihood of unintended pregnancies. The findings indicate that decisions to use family planning were shaped by multiple factors. For some participants, the use of family planning was driven by involvement in age-disparate relationships in which older men typically held greater socio-economic and decision-making power. For others, the pervasive threat of sexual violence in their communities motivated proactive contraceptive use, driven by the fear of pregnancy resulting from sexual abuse.

Regarding disclosing their use of family planning services to others, there was a significant divide between willing participants and those who were unwilling to disclose. The findings indicate that adolescents considered two key factors before deciding to reveal their SRH information to anyone: judgement and risk compensation among romantic partners. Participants who were willing to disclose their use of family planning anticipated acceptance, while those who did not want to disclose anticipated judgement. Moreover, the participants who were reluctant to disclose to their partners feared that revealing their use of family planning would lead their partners to neglect risk prevention measures during sexual activity.

5.2.2 Theme 2: Adolescent girls' knowledge about PrEP in Berea

To address the research sub-question, "What are the misconceptions about PrEP among adolescent girls who use family planning services in Berea, Lesotho?", it was crucial to first assess their level of PrEP knowledge. The findings indicate that 11 out of 12 participants knew about PrEP and had learned about it through various channels, including mass media, peer networks, and healthcare professionals. The participants correctly explained that PrEP was intended for HIV prevention among individuals who were at risk of HIV infection and that it must be taken daily for optimal effectiveness. However, beyond this, the participants were unable to describe any further benefits of using PrEP or remedial actions for missing the scheduled time to take it. This insufficient knowledge about PrEP potentially exposes girls to misinformation, which might discourage them from initiating and continuing PrEP use.

The study further assessed how other people's opinions about PrEP influenced the participants' perceptions, as adolescents usually model their behaviour on what they hear and the people they look up to when making decisions. The findings indicate negative community perceptions of PrEP, which stem from the fear of PrEP-related stigma. This study identified the fear of conflating PrEP with ARVs as one of the stigmatising ways in which communities discourage adolescents from using PrEP. Although there were also positive perceptions of PrEP's protective ability and its perceived benefits for young girls, many adolescent girls were still not inspired enough to take up PrEP. This study therefore indicates that adolescents' intentions to use PrEP are significantly influenced by perceptions of what others think. Because the participants believed people in their community lacked interest in PrEP, they too were inclined not to use it.

5.2.3 Theme 3: Social and psychological factors that affect PrEP uptake among adolescent girls

To explore the research sub-question, "What are the beliefs and attitudes towards PrEP among adolescent girls who use family planning services in Berea, Lesotho?", the study examined the participants' history of PrEP use to understand the lack of interest among adolescent girls who use family planning. The findings showed that five participants had never used PrEP, six stopped using it shortly after starting, and only one was using it at the time the interviews were conducted. When asked if they would consider taking PrEP if recommended by important others, only three showed some willingness, mainly as a last resort and with significant persuasion. The main barriers identified that prevented the participants from using PrEP included the following:

- Lack of social support: Some participants were discouraged from using PrEP because they feared they would not receive support from their parents and peer networks, and that their PrEP use would not be accepted.
- Conflation of PrEP with ARVs: The participants worried that people would mistake PrEP for HIV treatment and assume that PrEP users are HIV positive. Another concern was the association people made between PrEP use and promiscuity. As a result, they were reluctant to use PrEP for fear of being perceived as promiscuous and living with HIV.

- PrEP fatigue: Participants who discontinued PrEP indicated difficulty adhering to its daily administration, especially when they were not "ill". Those who had never taken PrEP also perceived daily dosages as a contributing barrier to taking it.
- Low perception of risk: The six participants stopped taking PrEP because they did not see themselves at an elevated risk of HIV infection. Similarly, the five participants who had never used PrEP also viewed it as unnecessary since they did not consider themselves vulnerable to HIV, despite engaging in risky sexual behaviours.
- Fear of stigma: The majority of the participants feared judgement for using PrEP. This fear stemmed from PrEP being perceived as a medication for people with low inhibitions who cannot control their sexual urges. The participants were concerned that using PrEP might invite questions from romantic partners about trust, loyalty, and fidelity in relationships.

5.2.4 Theme 4: The impact of stigma on the uptake of PrEP among adolescent girls

The study revealed intriguing contradictions while exploring how community perceptions of PrEP influenced the participants' decisions to use it, especially in relation to the research sub-question, "How does social stigma contribute to the low PrEP uptake among adolescent girls who use family planning services in Berea, Lesotho?" The findings indicate that adolescent girls in this study believed that other people's opinions about their PrEP use would not affect their decisions. The participants stated that PrEP users should not be discouraged from taking up or continuing to use PrEP because of what other people say. They believed that PrEP would benefit them greatly, given the social challenges they face, which increase their vulnerability to HIV. However, the findings also demonstrate that the majority of the participants were reluctant to use PrEP out of fear of being judged or stigmatised. On numerous occasions, the participants referenced the fear of being perceived as HIV positive and promiscuous for using PrEP, yet when asked whether other people's opinions mattered, they said no. The majority of the participants were not using PrEP because of this fear of judgement, which they ironically argued should not deter others.

Furthermore, this study found no evidence of stigma experienced as a result of using PrEP. The findings indicate that the participants could not recall experiencing judgement or seeing someone they knew become a victim of PrEP-related stigma. This included participants who had terminated their PrEP use and had disclosed their use of it. They did not experience actual stigma. Instead, the findings demonstrate that the fear of PrEP-related stigma stemmed from

internalised HIV-related stigma. Since the participants knew how people living with HIV were previously treated, they feared receiving the same treatment for using PrEP, due to the conflation of PrEP with ARVs. Therefore, because the stigma has been internalised, the participants anticipated falling victim to it if others knew about their PrEP use.

5.2.5 Theme 5: How accessible PrEP is to adolescent girls in Berea

This theme explored whether structural factors, particularly the availability and accessibility of PrEP, constituted barriers to its uptake. It addressed the research sub-question "Do limitations in the availability and accessibility of PrEP restrict its uptake among adolescent girls who use family planning services in Berea, Lesotho?" Regarding whether availability and access were deterrents to PrEP uptake, the findings indicate that most participants had access to places where they could obtain PrEP. Four participants had to use public transport to access SRH facilities because the local facilities were faith-based and did not offer SRH services. The study demonstrates that the participants knew where to go if they wanted PrEP. They also knew that PrEP was available at the same facilities where they obtained family planning services, and yet their PrEP uptake remained low. For participants who lived far from facilities and had to use public transport or walk long distances to access SRH services, the findings indicate that distance was not a deterrent, but the likelihood of inadvertent disclosure to parents who may not approve of such services was. Furthermore, through community outreach campaigns, facilities mitigate potential access barriers by bringing services closer to people. The study found that the factors identified in Section 5.2.3 were more likely deterrents to PrEP uptake among the participants.

5.3 Contributions of the study to existing knowledge

Most of the existing literature focuses on the uptake of PrEP among marginalised groups such as FSWs, members of the LGBTQI+ community, and MSM. In sub-Saharan Africa, much of the literature examines students' knowledge of PrEP and their willingness to use it. To a lesser extent, it explores the factors that lead to the discontinuation of PrEP among pregnant women and other users. Much remains unknown about the link between the use of birth control methods and HIV infection among young women in rural areas. The limited literature available is mainly biological and discusses how certain properties of oral contraceptives affect the biological makeup of women, thus increasing their susceptibility to HIV infection. This study situated itself within the existing literature by investigating the social factors that discourage

the uptake of PrEP among adolescent girls who are vulnerable to HIV due to their use of birth control methods. The study showed that many adolescent girls turn to family planning to prevent unintended pregnancies, which may result from their risky sexual behaviours, thereby elevating their risk of HIV.

The study further contributes to the existing knowledge in Lesotho about adolescent health and the social factors that inform the low uptake of PrEP among them, particularly those who are already making use of SRH interventions. The health sector in the country fully supports and encourages the integration of HIV prevention into the provision of SRH services to sexually active adolescent girls and adult women in Lesotho. However, despite this integration, the uptake of PrEP among adolescents remains low. This study therefore contributes to the understanding of the social factors that inform the health decision-making processes of adolescents who are already accessing birth control interventions regarding PrEP. The study helps to answer questions related to why knowledge and improved access to PrEP do not result in increased uptake. Furthermore, the study identifies the social factors that policymakers and service providers need to consider when developing strategies to enhance uptake among adolescents.

5.4 Recommendations for future research

This study successfully identified some of the social factors that inform the low uptake of PrEP among adolescent girls who use family planning services in Berea, Lesotho. Future research can build on this study's findings by investigating how male counterparts navigate PrEP uptake and the factors that affect it. Future research could also explore the role of partners and relationship dynamics in the uptake of PrEP. Investigating these factors among male counterparts and boyfriends would provide a holistic view of the factors that affect the uptake of PrEP among young people, as well as the influence that male partners have on their partners' decision making.

In this study, the focus was on older adolescent girls aged 18 and 19 years due to the ethical complexities surrounding age and consent for younger participants. Since the study established that some participants engaged in sexual intercourse from a very young age, future research could focus on the experiences of early teenagers. Studies focusing on younger adolescent girls could potentially provide valuable insights into early attitudes and barriers towards the uptake of PrEP.

Owing to new technologies and scientific research, new PrEP formulations are being introduced, such as lenacapavir or the twice-yearly injection, to enhance the uptake of PrEP among people at risk of HIV infection. This injectable option is intended to be administered twice a year and offers more protective features than pills. Future research could therefore investigate whether the introduction of these new injectables reduces concerns about pill burden, which may lead to PrEP fatigue, PrEP-related stigma, confidentiality issues, and other social factors that affect PrEP pill formulations.

5.5 Recommendations for healthcare service providers

Firstly, the lack of interest in PrEP among adolescent girls can largely be attributed to a lack of knowledge about PrEP and a low perception of need. Many adolescent girls may not consider themselves vulnerable to HIV, which reflects broader issues of SRH education. When adolescents do not see themselves as being at significant risk of HIV infection, they are less likely to seek HIV preventive measures such as PrEP. Healthcare service providers should therefore coordinate efforts to enhance access to comprehensive SRH information by conducting frequent outreach campaigns tailored to the specific needs of the target demographic. Health promotion messages must clearly articulate not only the mechanics of PrEP but also the realities of everyday life that expose adolescent girls to HIV in a relatable manner that will help them make informed health decisions. Through these campaigns, service providers must also create a safe environment where adolescents feel supported in discussing their concerns and experiences regarding PrEP and HIV risk more openly.

Secondly, the influence of social environments and peer opinions among adolescents cannot be overstated. The findings of this study reveal that negative perceptions about PrEP could stem from misinformation in peer groups. This could lead adolescent girls to internalise these negative views even if they do not have personal experience with PrEP. As a result, healthcare service providers may design health promotion messages and interventions with peer groups and sexual partners in mind. These messages must help adolescent girls recognise their true vulnerability to HIV and distinguish between pregnancy fears and HIV prevention needs. Targeting individuals who depend on others to make decisions may yield less positive results than targeting the very group or source of influence. Peer pressure and a desire for social acceptance are powerful motivators for adolescents; if the prevailing opinion is against a particular health intervention, it can deter them from considering it. It is essential to focus on

groups where opinions are formed, as it is easier for individuals to adopt an opinion that is supported by the group they affiliate with.

Lastly, adolescent girls refrain from using PrEP because it is conflated with ARVs and associated with promiscuity, immorality, and infidelity. The fear of being seen as HIV positive or as promiscuous discourages many adolescent girls from associating with PrEP in any way, even when they stand to benefit immensely from it, regardless of whether the stigma is actual or anticipated. Service providers would benefit from diversifying and strengthening health information sources and decentralising the provision of PrEP services to more neutral places, such as pharmacies, to address stigma-related concerns. Service providers must also consider promoting PrEP as an empowerment tool rather than using moralising language to enhance adolescents' resonance with the drug.

Most importantly, it would be prudent for healthcare providers to implement existing integration policies. Mechanisms should be established to facilitate the integration of PrEP into family planning services. This could involve pairing these services with PrEP counselling and routinely screening individuals who present for family planning services for PrEP eligibility. The aim is not to force users to take PrEP but to package family planning services with PrEP so that anyone seeking family planning, regardless of their motivations, is also educated about HIV prevention.

5.6 Limitations of the study

The study was unable to include younger adolescent girls in the inquiry into the social factors that affect the uptake of PrEP, which limited insights into the topic. As discussed in the section on researcher reflexivity, another limitation may have arisen from the researcher being male, which could have led the young female participants to moderate or censor their responses or provide answers they might not have given if the interviewer had been female. Lastly, the study's sample size was small and limited to adolescent girls accessing services at CoHiP SEC in Berea. Although the findings offer interesting insights into the social factors that affect the uptake of PrEP among adolescent girls, they cannot be generalised to adolescents in other districts or to the same project in different districts. However, the study can provide valuable insights for adolescent girls in similar circumstances in Lesotho.

5.7 Concluding remarks

Based on the findings of this study, the following concluding arguments can be made:

The lack of knowledge about PrEP is not a significant barrier to uptake among adolescent girls. They are aware of PrEP but are reluctant to use it. Access to PrEP does not appear to hinder adolescent girls from taking it. PrEP facilities were within reach for most participants, who knew that PrEP was also provided for free in facilities from which they obtain family planning services. The opinions of significant others contribute to adolescent girls' perceptions and ultimately their decisions regarding PrEP use. It is therefore imperative to involve adolescents' reference groups in health promotions. PrEP-related stigma is largely internalised. Efforts to address it should therefore begin internally, within potential PrEP users themselves. Addressing internalised stigma requires adolescent girls to recognise and challenge their own judgemental attitudes towards others. When they understand that they genuinely harbour no judgement towards others, they may come to believe that others will not perceive them with judgement for using PrEP and other SRH services.

It is my sincere hope that this study will benefit at least one adolescent girl navigating the challenges of adolescence by inspiring healthcare providers to develop strategies that address the social factors that contribute to the low uptake of PrEP. It is worth noting that while family planning addresses the need among adolescents for the prevention of unwanted and unintended pregnancies in areas with high prevalence rates of teenage pregnancy and HIV, such as Lesotho, it is equally important to also prevent HIV and other STIs to which adolescent girls are exposed. It would defeat the purpose if the uptake of one meaningful health intervention, such as family planning, were to reverse the gains made in other fields, such as the management of HIV and AIDS. Instead, the interventions should complement one another. This study does not suggest that adolescent girls are at risk of HIV solely by using family planning services. Rather, it seeks to establish that the factors that motivate the use of family planning might expose adolescent girls not only to unwanted pregnancies but also to HIV. It is therefore important for family planning users to also consider taking HIV prevention methods, due to the vulnerability they face. Ultimately, having addressed the aim of the study, which was to explore the social factors that influence the low uptake of PrEP among adolescent girls who use family planning services, service providers may leverage the findings to enhance the use of PrEP among adolescents who may find themselves at considerable risk of HIV related to using family planning services.

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APPENDICES

Appendix A: Ethical Clearance From the University of South Africa

UNISA university of south africa

College of Human Sciences_CREC

NHREC Registration # : (Rec-240816-052)
Ref #: 6956
Name: Mr Tsotang Moeketsi
Student #: 16198417

Date: 09/06/2025

Dear: Mr Tsotang Moeketsi

Decision: Ethics Approval from 09 June 2025 to 08 June 2026

Researcher: Mr Tsotang Moeketsi

Khubetsoana, Bochabela

Maseru

16198417@mylife.unisa.ac.za +266 58837405

Supervisor: Mr Tshepo Maake emaaketb@unisa.ac.za

Co-Supervisor: Ms Marie Matee mateem@unisa.ac.za

Exploring social factors that inform the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho.

Qualification: Master of Arts in Social and Behavioural Studies (HIV/AIDS)

Thank you for the application for research ethics clearance by the College of Human Sciences_CREC for the above-mentioned research study. Ethics approval is granted for one year.

The **high-risk application** was **reviewed** by the College of Human Sciences_CREC on **09 June 2025** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College of Human Sciences_CREC.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.

6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.

7. No field work activities may continue after the expiry date (**08 June 2026**). Submission of a completed research ethics progress report will constitute an application for renewal, for Ethics Research Committee approval.

Additional Conditions

1. Disclosure of data to third parties is prohibited without explicit consent from Unisa.
2. De-identified data must be safely stored on password protected PCs.
3. Care should be taken by the researcher when publishing the results to protect the confidentiality and privacy of the university.
4. Adherence to the National Statement on Ethical Research and Publication practices, principle 7 referring to Social awareness, must be ensured: "Researchers and institutions must be sensitive to the potential impact of their research on society, marginal groups or individuals, and must consider these when weighing the benefits of the research against any harmful effects, with a view to minimising or avoiding the latter where possible." Unisa will not be liable for any failure to comply with this principle.
5. Kindly note that the College of Human Sciences_CREC requires the submission of regular progress reports to be submitted {**quarterly**}. In line with section 7.2 of the Unisa Policy on Research Ethics (2024).

Note

The reference number 6956 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Kind regards,

Prof J K Malesa
Chair of College of Human Sciences_CREC
E-mail: maleskj@unisa.ac.za

Professor Omwoyo Bosire Onyancha
Executive Dean / By delegation from the Executive Dean of College of Human Sciences_CREC
E-mail: onyanob@unisa.ac.za

Appendix B: Ethical Clearance From the Lesotho National Health Research Ethics Committee

LESOTHO

Ministry of Health
P.O. Box 514
Maseru 100

Category of Review:
[x] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other _____

REF: ID 159-2025
Date: 11th April, 2025
To
Mr. Tsotang Moeketsi
Student Number: 16198417
University of South Africa

Dear **Mr. Moeketsi**

RE: Exploring social factors that inform the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho.

This is to inform you that the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[x] Protocol dated 20/03/2025
[x] **Informed Consent Forms (English& Sesotho):**
[x] **Data Collection Tool (English& Sesotho)::** Participant interview guide
[x] *Other participant's materials:* Information Sheet
[x] **Other materials**: Letter of permission to conduct a study dated 20/03/2025, Letter Addressing comments for Ethical Clearance approval dated 08/04/2025, Approval from The Sociology Departmental Higher Degrees Committee at Unisa dated 06 February 2025, CV_ Tsotang Moeketsi

This approval is **VALID** until April 02, 2026.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date. All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes. We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at mohrcu@gmail.com (or) 59037919/58800246.

Sincerely,

DR. 'MAKHOASE RANYALI - OTUBANJO
Director General Health Services

DR. LIMPHO MAILE
Member of National Health Research
Ethics Committee (NH-REC)

Appendix C: Approval Letter From the Comprehensive High Impact Community-Based HIV Prevention, Testing and Treatment Initiation for Sustained Epidemic Control

Private Bag A191 | Botšabelo
Near Queen 'Mamohato Memorial Hospital
Maseru 100, Lesotho

+266-2222-2700
info@baylorlesotho.org

15th June 2025

Tsotang Moeketsi

Student Number: 16198417

University of South Africa

Dear Sir

Research Title: ***Exploring Social Factors that Inform the low uptake of PrEP among Adolescent girls receiving Family Planning interventions from Donor-Funded projects in Berea, Lesotho- Ethical clearance (UNISA): 240816-052 Ref#: 6956***

This letter serves to inform you that Baylor Foundation Lesotho received your application to conduct the above research study in Berea District among Adolescents receiving services through a donor-funded project.

The request to collect data at Baylor clinic is **approved**.

The project teams are available to provide you support in any way needed for you to attain the study goals.

We wish you all the best in your studies.

Regards,

.....

Dr Mamello Moqhali Sekese

Technical Director

Baylor Foundation Lesotho

Appendix D: English Information Sheet

Research title: **Exploring social factors that inform the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho.**

Ethics clearance reference number: 6956

Research permission reference number: ID 159-2025

Dear Prospective Participant,

My name is Tsotang Moeketsi. I am conducting research supervised by Mr. Tshepo Maake and Mrs. Matee Marie in the Department of Sociology towards a Master of Arts degree at the University of South Africa. We invite you to participate in a study titled "Exploring social factors that influence the low uptake of PrEP among adolescent girls receiving family planning interventions from donor-funded projects in Berea, Lesotho".

WHAT IS THE PURPOSE OF THE STUDY?

This study aims to investigate why HIV prevention services, particularly PrEP, are not widely used by adolescent girls aged between 18 and 19 years in Berea, Lesotho. Globally, literature shows a rise in HIV infections within this group despite the availability of HIV prevention methods. Therefore, this study seeks to explore the social factors contributing to the low uptake of PrEP among adolescent girls who use birth control services in Berea, Lesotho. The findings will help improve health outcomes for adolescent girls, as they will be shared with service providers involved in HIV/AIDS prevention programmes across communities in Lesotho. Additionally, by identifying these factors and sharing the research findings, HIV prevention service providers may tailor their services to better resonate with adolescent girls, thereby increasing demand for PrEP.

WHY AM I BEING INVITED TO PARTICIPATE?

You have been chosen to participate in this study because of your valuable perspective on PrEP uptake as one of the adolescents using contraceptive services in Berea, Lesotho. Your insights into contraceptives and PrEP usage among adolescents will significantly aid the research, helping to uncover the key factors behind the low uptake of Prep. Additionally, your everyday experiences and interactions with peers who also use contraceptives will offer important

insights into perceptions and attitudes towards Prep. These contributions will support the development of intervention strategies aimed at increasing PrEP uptake among adolescent girls accessing birth control services. Please be assured that your personal details will remain confidential, and no information will be shared without your permission.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

Please note that the study involves audio recordings of semi-structured interviews. You will be asked to respond to several questions about your background, experiences, perceptions, and knowledge regarding the use of PrEP, from the perspective of someone who uses contraceptive services. The interview will take approximately 30 to 60 minutes and will be conducted via telephone.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Your participation is voluntary, and there is no penalty or loss of benefits for choosing not to participate. Participation in this study is voluntary, and you are under no obligation to give your consent. If you decide to take part, you will be given this information sheet to keep and asked to sign a written consent form. You are free to withdraw at any time, even without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no monetary incentives for participation. Your main benefit is that, by sharing your perspectives and experiences, you will contribute to a body of knowledge on the use of PrEP among adolescent girls living in Lesotho. Your responses influence how PrEP is perceived and will help raise awareness of its benefits within a community of adolescent girls who use contraceptive services, to enhance HIV prevention efforts and decrease new HIV infection rates.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

Participating in this research project poses no potential harm. You are protected from any accidental disclosures. The researcher will safeguard your information and will not reveal any identifying details of the study. Your personal information will remain confidential, and your real name will be replaced with a pseudonym.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Interview recordings will not be identified by your name, and no one apart from the researcher will be aware of your involvement in this research. Your answers will be assigned a code number or a pseudonym, and you will be referred to in this way in the data, publications, or other research reporting methods such as conference proceedings. Data will only be accessible to the researcher. Your anonymised data may be used for other purposes, including a research report, journal articles, and/or conference proceedings. A report of the study may be published, but it will not contain any information that could lead to your identification.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be destroyed after use. Electronic data will be stored in password-protected folders on Google Drive. Future use of the stored data will be subject to further Research Ethics Review and Approval if applicable. After a certain period, hard copies will be shredded and/or electronic copies permanently deleted.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

You will not receive any payments or incentives for participating. Arrangements for interviews will be made at no cost to you. Every effort will be taken to ensure you do not incur any financial expenses. You are not expected to make any phone calls to organise interviews.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee at UNISA and the Lesotho National Health Ethics Review Committee. A copy of the approval letter can be obtained from the researcher upon request.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you wish to be informed of the final research findings, please contact Tsotang Moeketsi at +266 58837405 or email tsowtang@yahoo.com. If you require any further information or wish to discuss any aspect of this study with the researcher, please also contact Tsotang Moeketsi on +266 58837405 or via email at tsowtang@yahoo.com.

If you have concerns about the way the research was conducted, you can contact Mr Tshepo Maake at 0124296576 or email emaaketb@unisa.ac.za. For ethical concerns, reach out to Professor J. Moodley, chairperson of the UNISA Research Ethics Review Committee, at moodljk@unisa.ac.za.

Thank you for taking the time to read this information sheet and for participating in this study.

Thank you.

Mr Tsotang Moeketsi

Appendix E: Tokomane ea Tlhahiso Leseling (Sesotho Information Sheet)

Sehlooho: Ho shebisisa mabaka a susumetsang ts'ebeliso e tlase ea litlhare tsa PrEP har'a baroetsana ba fumanang lits'ebeletso tsa thero ea malapa ho tsoa mererong e ts'ehelitsoeng ke bafani Berea, Lesotho.

Mohlomphehi,

Lebitso la ka ke Tsotang Moeketsi, ho tsoa sekolong se seholo sa Afrika Boroa (UNISA), tlasa lefapha la Sociology. Ke moithuti oa lengolo la boemo ba Master of Arts tlasa botataisi ba ntate Tshepo Maake le mme Matee Marie. Re u mema ho nka karolo boithutong ba hore na ke mabaka a fe a susumetsang ts'ebeliso e tlase ea litlhare tsa PrEP har'a baroetsana ba fumanang lits'ebeletso tsa thero ea malapa mererong e ts'ehelitsoeng ke bafani Berea, Lesotho.

SEPHEO SA BOITHUTO BOO KE SE FENG?

Boithuto bona bo reretsoe ho batlisisa hore na ke hobaneng lits'ebeletso tsa ho thibela ts'oaetso ea HIV, haholo-holo litlhare tsa PrEP, li sa sebelisoe haholo ke baroetsana ba lilemo tse lipakeng tsa leshome le metso e robeli (18) le leshome le metso e robong (19) seterekeng sa Berea, Lesotho. Lebaka ke hobane lefats'eng ka bophara, liphuphutso li supa hore ho na le sekhahla se phahameng sa ts'oaetso ea HIV sehlopheng sa baroetsana ba lilemo tsena, ho sa natse litsela tsohle tse teng tsa ho thibela ts'oaetso ea HIV. Ke ka lebaka lena boithuto bona bo lekang ho sibolla lintlha tse susumetsang ts'ebeliso e tlase ea litlhare tsa PrEP hara baroetsana ba sebelisang lithibela pelehi seterekeng sa Berea, Lesotho. Sena se tla ntlafatsa bophelo ba baroetsana, ka ha sephetho sa boithuto bona se tla aroleloa mafapha a amehang toants'ong ea HIV Lesotho. Hape, ka ho hloaea litlha tsena le ho phatlalatsa sephetho sa boithuto bona, bo mphato ba amehang toants'ong ea HIV Lesotho mona batla fumana mekhoa e meng e mecha e arabang litlhoko tsa baroetsana ba lilemo tsena e tla akofisa ts'ebeliso ea litlhare tsa PrEP.

HOBANENG KE MEMELOA HO NKA KAROLO BOITHUTONG BO?

U khethetsoe ho nka karolo hobane maikutlo a hau malebana le PrEP a le bohlokoa, ka ha u le e mongo a baroetsana ba sebelisang lits'ebeletso tsa lithibela pelehi seterekeng sa Berea, Lesotho. Maikutlo a hau mabapi le ts'ebeliso ea lithibela pelehi le PrEP ho baroetsana a tla tsoela boithuto bona molemo haholo, ka ho manolla lintho tse kenyang letsoho ts'ebelisong e tlase ea litlhare tsa PrEP. Ho feta moo, boikutlo le likamano tsa hau le methaka e sebelisang lithibela-pelehi li tla fana ka leseli la bohlokoa mabapi le maikutlo ka ts'ebeliso ea PrEP. Leseli

lena le tla thusa boithuto bona ho fana ka malebela a ho ntlafatsa ts'ebeliso ea PrEP har'a baroetsana ba sebelisang lits'ebeletso tsa thero ea Malapa. Ka kopo, ela hloko hore lintlha tsohle tsa hau tsa boitsebiso li tla bolokoa ele lekunutu, 'me ha hona lintlha li fe kapo li fe tse ka phatlalatsoang ntle le tumello e ahau.

SEMELO SA HO NKA KAROLO HOAKA BOITHUTONG BO KE SE FE?

Ela hloko hore boithuto bona bo kenyeletsa khatiso ea lipuisano le lethathamo la lipotso. U tla lebelloa hore u arabe lipotso mabapi le maikutlo, menahano, le tsebo ea hau ka PrEP, joalo ka motho ea sebelisang lits'ebeletso tsa thero ea Malapa.

NA NKA KHAOTSA HO NKA KAROLO LE HA KENE KE LUMETSE HO NKA KAROLO?

Ho nka karolo boithutong bona ke ka boithaopi, 'me u keke oa lefisoa kapo hona ho lahleheloa ke molemo oa letho ha u khetha ho se nke karolo. Ho nka karolo boithutong bona ke bolokolohing ba hau hape ha u tlasa khatello ea hore u nke karolo. Ha u khetha ho nka karolo, u tla fuoa tokomane ena ea litlhaloso hore u ipolokele eona, ebe u tla koptjoa ho Tekena tokomane ea tumellano. Hopola u bolokolohing ba ho emisa ho nka karolo nako eohle ntle le ho fana ka mabaka.

KE MELEMO E FE E TLANG LE HO NKA KAROLO?

Ha hona meropotso kapo litsiane tse fanoang bakeng sa ho nka karolo boithutong bona. Feela u ka una molemo ka hore ho nka karolo hoa hau le ho arolelana le rona litsebo le maikutlo a hau mabapi le ts'ebeliso ea PrEP ho tlo atsisa tsebo har'a baroetsana ba phelang Lesotho. Likarabo tsa hau li tla fana ka leseli mabapi le tsela eo karolo ea Sechaba e ikutloang ka PrEP, le ho tlisa tlhaiso leseling ka melemo ea ts'ebeliso ea PrEP ho baroetsana ba nkang lits'ebeletso tsa thero ea Malapa, e le hona ho ntlafatsa mekhoa ea ho thibela le ho fokotsa lits'oaetso tse ncha tsa HIV.

NA HO NA LE LITLA-MORAO TSA HO NKA KAROLO BOITHUTONG BO?

Ha ho kotsi e ka bang teng ho nka karolo boithutong bona. U sirelelitsoe khahlanong le ho senoleha hoa mofuta o fe kapo o fe o sa reroang. Lintlha tsohle tsa hau li sireletsehile 'me ha ho letho le amanang le uena le ka aroleloang batho ba bang. Boitsebiso bohle ba hau bot la bolokoa e le lekunutu, ebile u tla fuoa lebitso le iqapetsoeng ho sireletsa boitsebiso ba hau.

NA LINTLHA TSEO KE FANANG KA TSONA HO MOFUPUTSI LE BOITSEBISO BA KA BOT LA BOLOKOA E LE LEKUNUTU?

Likhatiso tsohle tsa puisano ea hau le mofuputsi li tla bolokoa tlasa mabitso a iqapetsoeng, ‘me ha hona motho ea tla tseba ho nka karolo ho ahau boithutong bona. Likarabo tsa hau li tla abeloa nomoro e ikhethileng kapo lebitso le iqapetsoeng, ‘me ho tla sebelisoa mabitso a na liphatlalatsong tsohle tse tlang ho latela. Likarabo tsohle li tla ba taolong ea mofuputsi. Likarabo tsa hau li ka sebelisoa mererong e meng, e kang tlaleho ea boithuto bona le liphatlalatso tse ka latelang. Tlaleho ea boithuto bona e kanna ea phatlalatsoa, empa ha hona letho le ka amahanyang boitsebiso ba hau le boithuto bona.

MOFUPUTSI O TLA SIRELETSA LINTLHA TSA RONA JOANG?

Litokomane tsohle tse sebelisitsoeng ho boloka likarabo tsa hau li tla senngoa kapo ho taboloa ka mora hore li sebelisoe. Lintlha tsohle tse bolokiloeng marang-rang li tla sireletsoa ka nomoro ea lekunutu e fanang ka tumello ea ho bula tokomane. Ts’ebeliso ea lintlha tsena ea ka moso e tla feta methati ea ho lekoloa ke baikarabellang mafapheng a lipatlisiso le ho netefatsa polokeho ea lipatlisiso tse joalo. Ka morao ho nako e joalo, litokomane tsohle li tla senngoa le lintlha tse bolokiloeng ho marang-rang li tla hlakoloa.

NA KE TLA PATALOA KAPO HONA HO FUOA LITSIANE TSA HO NKA KAROLO?

U ke ke oa pataloa kapo hona ho fumana meropotso e itseng bakeng sa ho nka karolo boithutong bona. Litlhophiso tsohle tsa lipuisano li tla etsoa ntle le litjeo ho uena. Mekutu e tla etsoa ho netefatsa hore ha u kene lits’enyehelong li fe kapo li fe. Ha ho oa lebelloa hore u ka tehela mofuputsi mohala.

NA BOITHUTO BO BO LUMELLETSOE KE MAFAPHA A AMEHANG?

Boithuto bona bo fumane tumello ea ho tsoelapele ho tsoa likomiting le mafapheng a amehang lekaleng la Bophelo Lesotho le sekolong UNISA. Tokomane tsena li ka fumaneha ha tlhoko e joalo e le teng.

KE TLA TSEBISOA JOANG KA SEPHETHO SA BOITHUTO BO?

Ha u lakatsa ho tsebisoa ka sephetho sa boithuto bona, ka kopa, ikopanye le Tsotang Moeketsi linomorong tsena +266 58837405 kapo mo ngolle ho tsowtang@yahoo.com. U ka sebelisa mecha e ts’oanang ho fumana lintlha tse ling ka botlalo mabapi le boithuto bona.

Ha u na le khoao mabapi le tsela eo boithuto bona bo etsoang, u ka tsebisa monghali Tshepo Maake linomorong tsena 0124296576 kapo oa mo ngolla ho emaaketb@unisa.ac.za. Hokahana le molula-setulo oa komiti e lekolang likopo tsa boithuto sekolong sa UNISA, Professor J. Moodley ho moodljk@unisa.ac.za ha u na le litletlebo ka polokeho ea boithuto bona.

Re leboha boikhathatso ba hau ho bala tokomane ena, le ho nka karolo boithutong bona.

Kea leboha

Tsotang Moeketsi

Moitekeno:

Appendix F: English Consent Form

UNISA university of south africa

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet. I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interview and the collection of raw data through notes taking. I confirm that I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname: Tsotang Moeketsi
Researcher's signature_____ Date……

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Appendix G: Tokomane Ea Ho Fana Ka Tumello (Sesotho Consent Form)

TUMELLO EA HO NKA KAROLO BOITHUTONG BONA

Nna, _____ (lebitso la ea nkang karolo), ke netefatsa hore motho ea kopang tumello ea ka ho nka karolo boithutong bona o ntsebisitse ka botlalo mofuta, mekhoa le melemo e ka lebelloang, e ka sita le liqholotso tse ka lebelloang ha ke nka karolo.

Ke balile (kapo ke hlaloselitsoe) ‘me ke utloisisa morero le sepheo sa boithuto bona joalo kaha ho hlalositsoe ka har’a tokomane e fanang ka tlhaloso. Ke bile le nako e lekaneng ho botsa lipotso le ho fumana litlhakisetso, ‘me ke ikemiselitse ho ithaopela ho nka karolo boithutong bona.

Kea utloisisa hore ho nka karolo boithutong bona ke boithaopong ba ka ‘me ke lokolohile hore nka khaotsa ho nka karolo neng kapo neng ha ke batla ntle le lipehelo.

Ke etse hloko hore sephetho sa boithuto bona se tla sebelisoa ho etsa tlaleho ea boithuto, le liphatlalatso tse ling, le hore ho nka karolo hoa ka ho tla bolokoa e le lekunutu, ntle le ha ho ka etsoa tlhophiso e nngoe.

Ke fana ka tumello ea hore puisano eaka le mofuputsi e ka hatisoa le hore mofuputsi a ka ngola fats’e lintlha tsa bohlokoa ho tsoa puisanong ea rona.

Ke netefatsa mona hore ke fumane tokomane e tekennoeng moo ke fanang ka tumello ea ho nka karolo boithuto bona.

Lebitso le fane tsa ea nkang karolo: _____ (ka tlhaku tse kholo)

Motekeno oa ea nkang karolo: _____ Letsatsi_____

Lebitso le fane tsa mofuputsi: _____ (ka tlhaku tse kholo)

Motekeno oa mofuputsi: _____ Letsatsi: _____

Appendix H: English Interview Guide

What are the social factors that inform the low uptake of PrEP among adolescent girls receiving family planning services in Berea, Lesotho?

1. Demographic information

1.1 Where do you stay?

1.2 What is your age?

1.3 What is your highest level of education?

1.4 What is your marital status?

2. Background on family planning

2.1 How did you find out about the family planning services?

2.2 How long have you been using family planning services?

2.3 Why do you use family planning services?

2.4 Have you told anyone about your use of family planning services? Why?

2.5 Would you recommend family planning services to any of your peers? How do you think they would react?

3. What are the misconceptions about PrEP among adolescent girls receiving family planning services in Berea, Lesotho?

3.1 Have you heard about PrEP before?

3.2 How did you come to know about PrEP?

3.3 Tell about some of the advantages for taking PrEP you know.

3.4 What are some disadvantages for using PrEP?

3.5 What do your friends think about PrEP use?

3.6 What does it take for PrEP to work well?

3.7 Would you recommend PrEP to any of you friends? Please tell me why you would recommend it. How do you think they would react?

4. What are the beliefs and attitudes towards PrEP among adolescent girls receiving family planning services in Berea, Lesotho?

4.1 Have you ever taken PrEP?

4.2 Do you think PrEP can influence a person's sexual behaviour? If so, how? If not, why?

4.3 Would you take PrEP if it was offered? Why?

4.4 Do you think PrEP is meant for certain people only?

4.5 Would you take PrEP if someone important to you, like a friend or a pastor, encouraged you to take PrEP?

5. How does social stigma inform the low uptake of PrEP among adolescent girls receiving family planning services in Berea, Lesotho?

5.1 Is it right or wrong for adolescent girls to use PrEP? Why?

5.2 Do you think it matters how other people feel about people who use PrEP?

5.3 How do you think people around you would react to your use of PrEP?

5.4 Do you know of anyone who was treated unfairly simply because they use PrEP? If so, can you tell me about it?

5.5 If you were using PrEP, would you want people to know? Why?

5.6 What do you think can be done to reduce stigma against people who use PrEP?

6. How available and accessible is PrEP to adolescent girls receiving family planning services in Berea, Lesotho?

6.1 If you were considering using PrEP, would you know where to find it?

6.2 How far are the services? Is it within walking distance or would you need to take a taxi?

6.3 Do you know if PrEP and family planning services can be found in one place in your community?

6.4 What do you think can be done to make PrEP more accessible to adolescent girls receiving family planning services?

7. Do you have any questions you would like to ask?

Appendix I: Tataiso Ea Lethathamo La Lipotso Tsa Ea Nkang Karolo (Sesotho Interview Guide)

TLHAHLOBO EA MABAKA A SUSUMETSANG TS'EBELISO E TLASE EA PREP HAR'A BAROETSANA BA FUMANANG LITS'EBELETSO TSA THERO EA MALAPA HO TSOA MERERONG E TS'EHELITSOENG KE BAFANI BEREA, LESOTHO

Lipehelo

Tokomane e fanang ka tlhaloso ea boithuto bona le e fanang ka tumello ea ho nka karolo boithutong bona li tla fanoa pele lipuisano li ka qala moo ho botsoang lipotso. Lipuisano li tla tsoelapele ha feela ba nkang karolo ba balile le ho utloisisa boithuto bona, ebile ba fanne ka tumello e tekennoeng ea ho nka karolo boithutong bona, hore ba ka botsoa lipotso.

LIPOTSO

1. LINTLHA TSA BOITSEBISO

1.1 U lula kae?

1.2 U lilemo li kae?

1.3 Thuto ea hau e holimo ke e feng?

2. TSEBO KA TS'EBELETSO EA THERO EA MALAPA

2.1 U tsebile joang ka lits'ebeletso tsa thero ea malapa?

2.2 U na le nako e kae u sebelisa lits'ebeletso tsa thero ea malapa?

2.3 U ka re ke hobaneng u sebelisa lits'ebeletso tsa thero ea malapa?

2.4 Na u kile oa joetsa motho e mong ka ts'ebeliso ea hau ea lits'ebeletso tsa thero ea malapa? E kaba ke hobaneng?

2.5 Na u ka khothaletsa lits'ebeletso tsa thero ea malapa ho e meng ea metsoalle ea hau? U nahana ba ka ikutloa joang?

3. KE MAFOSISA A FE KA PREP A TENG HAR'A BAROETSANA BA FUMANANG LITS'EBELETSO TSA THERO EA MALAPA BEREA, LESOTHO?

3.1 Na u kile oa utloela ka PrEP?

3.2 U tsebile joang ka PrEP?

3.3 U ka ntjoetsa ka e meng ea melemo ea ho sebelisa PrEP eo u e tsebang?

3.4 Litla-morao tsa ho sebelisa PrEP e ka ba li fe?

3.5 Metsoalle ea hau e nahana joang ka ts'ebeliso ea PrEP?

3.6 Ke joang PrEP e ka sebetsang hantle?

3.7 U ka khothaletsa metsoalle ea hau ho sebelisa PrEP? U ka re ke hobaneng u ka khothaletsa ts'ebeliso ea PrEP? U nahana ba ka ikutloa joang?

4. KE LITUMELO LE MAIKUTLO A FE KHAHLANONG LE TS'EBELISO EA PREP HAR'A BAROETSANA BA FUMANANG LITS'EBELETSO TSA THERO EA MALAPA?

4.1 Na u kile oa sebelisa PrEP?

4.2 U nahana hore ts'ebeliso ea PrEP e ka susumetsa boits'oaro ba motho mabapi le thobalano? U ka hlalosa na ke hobaneng?

4.3 U ka sebelisa PrEP ha eba u no ka e khothaletsoa? E be ke hobaneng?

4.4 Na u nahana PrEP e reretsoe batho ba itseng feela?

4.5 Na u ka sebelisa PrEP ha motho oa bohlokoa ho uena, joalo ka motsoalle kapa moruti a ka u khothaletsa ho e sebelisa?

5. KE KA TSELA E FE SEKHOBO SE KA SUSUMETSANG TS'EBELISO E TLASE EA PREP HAR'A BAROETSANA BA FUMANANG LITS'EBELETSO TSA THERO EA MALAPA BEREA, LESOTHO?

5.1 Ke ntho e nepahetseng kapo e fosahetseng hore baroetsana ba sebelise PrEP? Hobaneng ho le joalo?

5.2 Na u nahana ho bohlokoa hore na batho ba bang ba ikutloa joang ka ts'ebeliso ea PrEP?

5.3 U nahana batho ba pela hau ba ka itkutloa joang ha u sebelisa PrEP?

5.4 Na hona le motho eo u mo tsebang ea kileng a sekisetsoa ka lebaka la ts'ebeliso ea PrEP? Ha ho le joalo, u ka nqoqela haholoanyane?

5.5 Ha ebe u no sebelisa PrEP, na u ne u ka batla hore batho ba tsebe? Hobaneng?

5.6 U nahana ho ka etsoa eng ho fokotsa sekhobo ho batho ba sebelisang PrEP?

6. PREP E FUMANEHA HO LE HO KAE HO BAROETSANA BA FUMANANG LITS'EBELETSO TSA THERO EA MALAPA?

6.1 Ha eba u ne u batla ho sebelisa PrEP, na u tseba moo u neng u ka e fumana?

6.2 Lits'ebeletso li hole kapo li haufi ho le hokae le uena? U ka fihla ka maoto kapo u ka tlameha ho sebelisa likoloi tsa baeti?

6.3 U ka tseba hore na lits'ebeletso tsa PrEP le thero ea malapa li ka fumaneha sebakeng se le seng tikolohong ea hau?

6.4 Ke eng se ka etsoang ho akofisa phumaneho ea PrEP molemong oa baroetsana ba sebelisang lits'ebeletso tsa thero ea Malapa?

7. NA U KA BA LE LIPOTSO TSEO U KA LAKATSANG HO LI BOTSA?

Appendix J: Similarity Report

Similarity Report

● **11% Overall Similarity**

Top sources found in the following databases:

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Sources overview

Appendix K: Editing Letter

GRAMMAR GUARDIANS

25 February 2026

To whom it may concern

Re: Proofreading and academic editing: Mr T. Moeketsi

I, Ms Jeanne-Louise van Aswegen, hereby confirm proofreading and academic editing of the master's thesis entitled *Exploring Social Factors That Inform the Low Uptake of PrEP Among Adolescent Girls Receiving Family Planning Interventions From Donor-Funded Projects in Berea, Lesotho* by Tsotang Moeketsi (student number 16198417) in February 2026 (excluding the reference list and annexures). The editor is not liable for post-editing changes made by the researcher.

Please contact me on 082 811 6857 or at jeanne@grammarguardians.co.za regarding any queries that may arise.

Kind regards,

J.L. van Aswegen

Grammar Guardians