Challenges of Accessing Family Planning Services by Women of Reproductive Age in Maseru Industrial Areas

By

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DECLARATION

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I declare that the study on “Challenges of Accessing Family Planning Services by Women of Reproductive Age in Maseru Industrial Areas” is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

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Signature

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Abstract

The focus of the study was on challenges faced by women of reproductive age when accessing family planning services in Maseru. The research is qualitative in nature as it sought to enable the respondents to express themselves without many interruptions. The socio-economic as well as cultural and health factors that influence women's access to contraceptives have been documented in the study. The study findings revealed that there is high knowledge of contraceptive use among women. Respondents used mostly pills and injections. The health-related effects of using these contraceptives such as weight-gain, heavy menstrual flow and nausea resulted into some women no longer seeking family planning services even when they had confided in the healthcare worker about their problems.

Contraceptives are accessed freely in public hospitals and clinics in Lesotho but young women in the study stated that they often buy expensive contraceptives in private clinics and hospitals to avoid humiliating questions that health workers in public hospitals and clinics ask them. However, married women are treated better in healthcare facilities when they seek contraceptives.

COVID-19 also became a challenge for women to access contraceptives in Lesotho due to the strict lockdowns that were put in place by the government to curb the spread of the disease in 2020. This resulted in movement restrictions and when some women did manage to visit hospitals to get contraceptives, security officials would often harass them which influenced them to sometimes not get their contraceptive package. Long queues and congestion in hospitals made some women not to seek services as they feared contracting COVID-19. Shortage on contraception method of choice also made some women to abandon use of contraceptives. With these various challenges, the researcher advices the government to make contraceptive access adolescent-youth friendly so that young people receiving the services express themselves freely instead of feeling prejudiced. Access to family planning services should be there all the time even in pandemics like that of COVID-19. COVID-19 should, in fact, serve as a lesson in strengthening access. Contraceptive access and, delivery should not be hampered and, the policy makers, health rights activists should keep on reminding the government

and relevant stakeholders in the delivery of family planning services to prioritize the delivery of family planning, and should also not leave men behind in this discourse. They have a crucial role in the drive for women to access family planning services effectively.

Contents

List of Abbreviations and Acronyms

AIDS Acquired Immunodeficiency Syndrome

APHRC African Population and Health Research Center

CEDAW United Nations Convention on the Elimination of Discrimination Against Women

CRR Center for Reproductive Rights

CHAL Christian Health Association of Lesotho

CPR Contraception Prevalence Rate

HIV Human Immunodeficiency Virus

ICPD International Conference on Population and Development

IPPF International Planned Parenthood Federation

IUD Intra-Uterine Device

FPS Family Planning Services

LARCs Long-Acting Reversible Contraceptives

LAM Lactation Ammorhoea Method

LDHS Lesotho Demographic Health Survey

LECSA Lesotho Evangelical Church of Southern Africa

LPPA Lesotho Planned Parenthood Association

NGOs Non Governmental Organizations

NUL National University of Lesotho

OCPs Oral Contraceptive Pills

PPE Personal Protective Equipment

PPG **Planned Parenthood Global**

RCC **Roman Catholic Church**

SDGs **Sustainable Development Goals**

SGBV **Sexual and Gender-Based Violence**

SRHR **Sexual, Reproductive, Health and Rights**

SSA **Sub Saharan Africa**

STIDs **Sexually Transmitted Diseases**

STIs **Sexually Transmitted Infections**

UN **United Nations**

UNFPA **United Nations Population Fund**

USAID **United States Agency for International Development**

WBG **World Bank Group**

Chapter One

Introduction

1.0 Background to the Study

When modern family planning movement began in the early 20th Century in the global north (western countries), its goal was to liberate women from social and health consequences of unwanted pregnancies. When organized family planning programmes reached the developing world in the early 1950s, these programmes were viewed as the means to help reduce the pressure of rapid population growth on economic development and growth. In the last few decades, the purpose of family planning has broadened to encompass both these objectives and the objective of improving women's health and welfare (Indongo 2007).

Family planning means the use of contraceptives or other steps that intimate partners use to plan for the number and spacing (birth interval) of their children (Ochako, Askew, and Okal, 2016). Sustainable Development Goal 3 (Good Health and Well-Being) 's target 3.7 is to ensure access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs across the world (Boadu 2022). There are various forms of contraceptives such as sterilization, abortion, contraception pills and employing other natural methods to prevent pregnancy. The decision to use contraceptives help couples to get the desired number of children and also to space the children (Osore, 2016). In Sub-Saharan Africa women face a number of issues when they have to use modern contraceptives like pills, injections and condoms. The issues they face include lack of information, women's inability to make family decisions on their own, cultural beliefs, and inaccessibility of health facilities and poverty (Tsui, Brown and Li, 2017).

1.1 International Treaties that Lesotho is Signatory to on Family Planning

In the past decades, in part as a result of HIV/AIDS pandemic, young people and their health needs have been given more attention, especially in the developing countries.

Various international forums and conferences have been held to address family planning issues and those in the field of reproductive health and rights have tried to consolidate their voices and ideas to bring them into reality. For instance, international conferences have been held, the first of its kind being the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, and forums such as the 1999 World Youth Forum held at Hague, Netherlands and, the African Forum on Adolescent Reproductive Health held in 2013 in Addis Ababa, Ethiopia following(Indongo 2007). At the Cairo conference, all signatory countries, Lesotho included, were advised to make sexual, reproductive and health services available for all individuals of appropriate age and to put in place an institutional, legislative and policy environment that facilitated the implementation of ICPD Programme of Action (UNFPA Lesotho, 2019).Despite remarkable progress of ICPD in developed nations over the decades, the implementation of ICPD Programme of Action has not been achieved for millions of people across the developing world. Universal access to the full range of sexual, reproductive and health information, education, and services outlined in the ICPD Programme of Action, and the key Actions for the further implementation have not been achieved (UNFPA Lesotho, 2019). During the months leading to the 25th Anniversary of International Conference on Population and Development (ICPD25) held on the 12th to 14th November 2019 in Nairobi, Kenya, commitments were made. Young representatives in Lesotho from grassroots movements consolidated and signed a commitment on accelerating the implementation of ICPD Program of Action. The country was commended on making notable progress over the last two decades in increasing access to sexual, reproductive and health services (UNFPA Lesotho, 2020).

Lesotho is a signatory to various international treaties; for instance, the United Nations Convention on the Elimination of Discrimination Against Women (CEDAW). The country has also ratified the African Union's Protocol on the African Charter on Human and Peoples' Rights on the Rights of Women in Africa known as Maputo Protocol adopted in Maputo, Mozambique in 2003. The Maputo Protocol promises comprehensive rights to women including the right to be on the same foot with men politically, and the right to make their own decisions regarding their reproductive organs amongst other things (Obasi, 2017).

1.2 History of Family Planning Access in Lesotho

According to Tuoane, Madise and Diamond (2004), the government of Lesotho formed and approved the Lesotho Planned Parenthood Association (LPPA) in 1968 to provide family planning services to Basotho; the focus was put on women after debating on the negative attitudes that would come from the pronatalists. However, the government became fully involved with the family planning activities in the 1970s with little known about contraception at the time. For instance, in 1977, only 7% of married women of reproductive age were using contraceptives (Tuoane, Diamond and Madise, 2003).

Decades later, contraceptive use in Lesotho in 1998 was estimated at 23% but has reached 70% among married women and 72% unmarried women (Lesotho Demographic Health Survey, 2014). In Lesotho, 63% of women receive family planning services in public hospitals and 37% in private hospitals and clinics. The use of injections (81%) implants (81%) and pills (62%) are the most used modern methods of contraceptives by women of reproductive age in Lesotho.

The Ministry of Health has the overall responsibility for managing national family planning program. The Ministry together with the Lesotho Planned Parenthood Association (LPPA) are the main providers of family planning services; other providers include the Christian Health Association of Lesotho (CHAL), the Red Cross and the private practitioners. Funding for family planning also comes from various donors, including the United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID). The government of Lesotho is therefore committed to allocating 5% of its annual budget to the Ministry of Health of which 40% goes to Maternal and Child Health and Family Planning Departments (Guttmacher.org, 2004).

The COVID-19 pandemic has also created barriers for women and adolescent girls in accessing family planning services across the world. Pokhrel, (2020) posits that adolescent girls and young women faced a lot of problems in accessing essential sexual, reproductive, and health information and services like use of contraceptives before the COVID-19 crisis. The COVID-19 pandemic was said to be straining even the most advanced healthcare systems, and there was a risk that the rights to access contraceptives was going be a challenge for the majority of women. With full or partial

COVID-19 lockdown, an overwhelming number of countries reported significant increase in sexual and gender-based violence (SGBV) cases, including those in Europe like France which reported 32% of spike in domestic violence. Failure for victims of SGBV to access healthcare services as a result of lockdowns exposed them to high risk of getting pregnant.

Despite these threats to women's reproductive health rights, resources are being diverted away from family planning services like access to contraceptives to prevent pregnancies as well as counseling and legal services to victims of sexual and domestic abuse (EPF & IPPF, 2020). Even some developed countries like Austria, Denmark and Germany were forced to reduce contraceptive access as it was considered non-essential at the beginning of the COVID-19 pandemic. People seeking family planning services were turned away or told to wait for a long time which led to unintended pregnancies for those who did not receive the services (European Parliamentary Forum, 2020).

1.3 Family Planning Access in Lesotho during COVID-19 Lockdowns

United Population Fund (2021), analysis indicated that COVID-19 restrictions put by the government of Lesotho led to a 14% drop in number of family planning delivery in some districts compared to 2019. The analysis revealed that the reason for the decline in family planning included strikes that were organized by healthcare providers due to lack of Personal Protective Equipment (PPE) in July 2020. The health workers did not also consider family planning service an essential service during the time of lockdown. The most significant drop in access to FP services was noted in Quthing district with a 40% decline in family planning visits from March to July 2020 compared to 2019. The districts where the services were already poor before the COVID-19 lockdown saw the greatest drop as a result of the lockdown measures.

1.4 Statement of the Problem

Lack of access to family planning services has been a public health problem in many Sub-Saharan African countries. The governments had shown no interest on the help that the international community on population/family planning provided in the 1980s

through the 1990s (Tsui, Brown and Li, 2017). According to Tilahun (2014),even in recent times there is little focus in Sub-Saharan Africa on matters dealing with family planning from a mere 27.4% in 1990 to 25% in 2011.In Lesotho, lack of access for family planning among married women has decreased significantly over the years, from 31% in 2004, 23% in 2009 and 18% in 2014 (LDHS 2014). Studies show that unmet need is higher among unmarried young women in Lesotho (Akintade, 2010).

Academics such as Ajayi et al, (2021), Mwamba, Mayers and Shea (2022) and Berhe et al, (2022) in the field of sexual, reproductive, health and rights (SRHR) have reviewed demand for contraception in 88 low-and-middle income countries that rely on donors for contraceptive access (IPPF, 2011). They found that the number of women of reproductive age was going to increase by one-third in 15 years, reaching nearly 696 million by 2020. The percentage of women using modern contraception has been increasing in the developing countries. Even in Sub-Saharan Africa, the use of modern contraception has been on a rise, but 33% of married and never married lacked access to contraception (IPPF, 2011). The study aimed to find the practical solutions to the challenges women of reproductive age faced when accessing family planning services in Maseru Industrial Areas.

1.5 Research Objectives

The present study had main objective and specific objectives**.**

Main Objective

The main objective of the study was to investigate challenges faced by women of reproductive age in accessing family planning services in Maseru Industrial Areas.

Specific Objectives

1) To inspect whether socio-cultural constraints are a barrier to accessing family planning services;

2) To find out the economic constraints women of reproductive age face in accessing family planning services and

3) To explore healthcare providers' attitudes towards the women when accessing family planning services

1.6 Research Questions

The study was guided by the questions listed below;

I. Are modern family planning methods accessible and available to women of reproductive age?

II. What are the socio-cultural constraints that hinder women of reproductive age from accessing family planning services?

III. What are the economic constraints that impede women's access to contraceptives?

IV. What are the healthcare providers' attitudes towards women when accessing family planning services?

1.7 Justification of the Study

Contraceptive prevalence rate for women in Lesotho was 37% in 2004, in which case one third (35%) of married women used modern method while only 2% used traditional method of contraceptives. Contraceptive use was highest among sexually active unmarried women (48%) in 2004 (LDHS, 2004). Despite the overwhelming increase (79%) in the demand for contraceptives by women in Lesotho by the year 2014, only 60% have access to family planning services, while 18% have unmet need, therefore, not using any modern contraception method(LDHS,2014).

Apart from being a requirement for graduation, conducting the study among young people in Lesotho will serve as a way to get an account on the challenges women of reproductive age, especially young women, continue to face in accessing family planning services. The study, through dissemination of findings, will also serve to inform or engage policy-makers and relevant stakeholders involved in the delivery of family planning services to improve in the quality of family planning services.

1.8 Concepts

Contraceptives and family planning services will be used interchangeably in the report of this study.

1.8.1 Contraceptives

Jain and Muralidhar (2011), define contraceptives as intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs or surgical procedures. An effective contraception allows physical relationship without fear of an unwanted pregnancy and ensures freedom to have children when desired. Pills and injections use as methods of contraceptives will be the focus of this study.

1.8.2 Family Planning Services

WHO (2010) describes family planning as the ability of individuals and couples who get their desired number of children and the spacing and timing of their birth. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. Family planning has three purposes; it helps couples avoid unwanted pregnancies, it reduces the spread of STDs, and it helps reduce the rates of infertility. Family planning in this study refers to the ability of women or partners to have control or limit over the number of children to have using modern contraception methods.

1.8.3 Women of Reproductive Age

WRA refers to those between the ages of 15-49 who are married or in a union and have their need for family planning satisfied with modern methods of contraception, (LDHS, 2014). In this study, women of reproductive age refers to those that are between the ages of 18 and 35 years whether married or unmarried and, from whom data was collected

1.8.4 Youth

Youth is defined as persons between the ages of 15 and 35 years, (Ministry of Gender and Youth, Sports and Recreation-2006). In this study youth comprises people between the ages of 18 and 35 years with a focus on females.

1.9 Conclusion

The chapter focused on the history of women's use of modern family planning services dating back to the 20th century and its vital importance in the liberation of women from health and social consequences of unplanned pregnancies. Lesotho is part of many initiatives such as the Lesotho Planned Parenthood Association established in 1968 to focus on family planning and it joined numerous multilateral international institutions that safeguard the welfare, health and the rights of women and vulnerable groups. The chapter also outlined the main players in the delivery of modern family planning methods in Lesotho. The problem statement, research objectives, research questions as well as study justification have been outlined. The terms or concepts vital for the study have been explained.

Chapter Two

Literature Review and Theoretical Framework

2.0 Introduction

The chapter covers the literature review on challenges faced by women of reproductive age in accessing family planning services. The Law of Supply and Demand Theory used in the study is also discussed. The chapter is organized such that the theoretical framework precedes literature.

2.1 Theoretical Framework

The Demand and Supply has been used or applied in previous studies for decades in the delivery of family planning services and health sector generally. The theory has been used by Mabele (2010) in her dissertation "Determinants of Contraceptive Use among Young Women in Lesotho" while Indongo also used the theory on her 2007 thesis on "Contraceptive Use among Young Women in Namibia: Determinants and Policy Implications". I found the theory also applicable to the study which focuses on "Challenges of Accessing Family Planning Services by Women of Reproductive Age in Maseru Industrial Areas".

Population does count in world economies, especially in the African continent that is experiencing population boom that is to increase by 50% over the next 18 years to 1.8 billion by 2035, therefore, the issues of population control are slowly being prioritized (Bello-Schuneman, 2017). Mabele (2010) states that there has to be demand in order for goods and services to be supplied and in this case there is a demand for contraceptives. The use of contraceptives/ birth control limit births and help in child-spacing. This has an important role in countries with high population growth rate that does not match with economic growth (Mabele, 2010). In order to try to meet the contraceptive demands of young people, the government of Lesotho, through Non-Governmental Organizations such as the United Nations Population Fund (UNFPA) and Lesotho Planned Parenthood Association (LPPA) is accelerating the delivery of family

planning services by introducing youth corners that provide safe spaces for sex education and mobile clinics that are easy to access.

Law of Demand and Supply Theory

According to Parkin, Powell and Matthews (2005), the law of supply and demand is an economic theory that was made famous by Adam Smith in 1776. Demand refers to the connection of the price of a good and the quantity of a good demanded. The law of demand stipulates that, the more expensive a good is, the smaller the quantity is demanded; the cheaper the price of a good, the more quantity demanded. Supply refers to the correlation between the quantity supplied and the price of the good. The law of supply states that, the more expensive the price of a good, the more is the quantity supplied; the cheaper the price of a good, the little is supplied (Parkin, Powell & Mathews, 2005).

The delivery of family planning services is determined by demand and supply. The demand and the supply of contraceptives are interdependent. As women's demand for contraception increases, the need for governments, donors, manufacturers and other stakeholders to meet and supply contraceptives become increasingly critical. The increase in the demand for modern contraception use by women is driven by several factors: the number of women reproducing, the number of contraceptive users, changing method mix (more use of modern methods), increasing knowledge and awareness of family planning, and the attitudes of society about family size (International Planned Parenthood Federation, 2011).

If there is a demand for contraception, the world has a duty to meet the demand. Various ideas and solutions should make sure that there is a supply of a range of affordable contraceptives accessible to women (IPPF, 2011). Mabele (2010) asserts that in society, things that can drive the use contraceptives could be the community fertility preferences and attitudes towards family planning, the availability of method of choice, outreach programmes to different groups and the follow-up care. Tuoane, Madise and Diamond (2003) state that the supply of contraceptives is shaped by

financial backing, regulations, political commitment and organizational factors such as infrastructure, delivery system, access and cost, quality of skills of staff and services. According to Jabeen, Rathor, Riaz and Fischer (2020), knowledge, spreading awareness and positive attitude create the demand for contraceptives. In Lesotho, accessing family planning services can be influenced by the location of the dispensaries and community based distribution (CBD) offering contraceptives in rural communities (Mabele, 2010).The urban-rural divide in Lesotho is marked with the rural population reporting considerably limited access of contraceptives than in urban areas (East, Central and Southern Africa Health Community and Ministry of Health and Social Welfare, 2011). In Lesotho for example, married women (65%) in urban areas are more likely to use contraceptives than married women (57%) in rural areas, with notable difference across the districts. Use of modern contraceptives among married women ranges from 48% use in Mokhotlong to 64% use in Berea and Quthing districts (Lesotho Demographic Health Survey, 2014).

The demand for contraceptive is driven by availability on the choice of contraceptive. Improving quality of services is likely to led to an increase in the demand of contraceptives, as women will be determined to use, if the service is poor, the demand for contraceptive use will decrease (Mabele, 2010). In Lesotho, 18% of women still lack access to contraceptives,(LDHS, 2014). The Law of Demand and Supply was used to find the challenges faced by women of reproductive age when accessing family planning services. This helped on tracking what drives demand and supply as well as what makes contraception use a challenge for women.

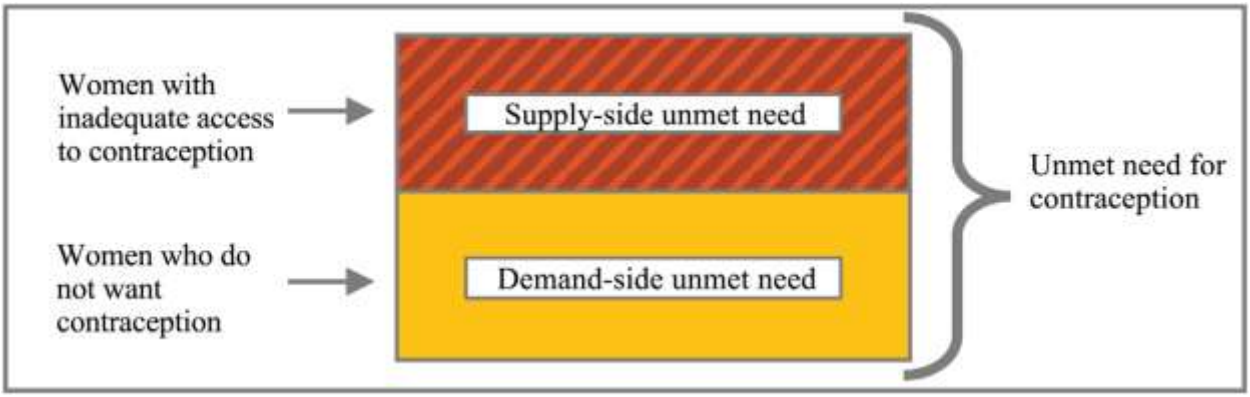


Figure 1 Conceptual Model of Supply-Side and Demand-Side Unmet Need for Contraception (Serenderowics and Maloney 2022)

Women's inadequate access to contraception or challenge to accessing it as demonstrated in Figure 1 is above is influenced by the supply-side related issues be it logistics regarding contraceptive supply, shortage of modern contraceptives method of choice, distance, cost of contraceptives and knowledge barriers due to low educational outcomes according to Serenderowics and Maloney (2022).

The demand-side of unmet need for contraception is similarly related to the supply-side except that the low demand for contraception in this case may be influenced by women's low sexual encounters, health-related side effects and religion playing role in married women's reluctance to use.

2.2 Family Planning in Sub-Saharan Africa

According to Bado, Badolo and Zoma (2020), family planning programmes are important components in combating maternal and child mortality rates, as it allows women to delay, space, or limit their pregnancies, this involves a conscious decision. In Sub-Saharan Africa, despite the benefits of family planning, indicators of fertility, and the desire to limit family size, the use of modern contraceptives are among the lowest in the world. Nearly 25% of young women in SSA (about 47 million) have unmet need (Ahinkorah, Ameyaw and Seidu, 2020). Due to this shortage, fertility rates vary across five regions of Africa; from 2.38 births per woman in Southern Africa to 3.05 in Northern Africa, to 4.52 in Eastern Africa to 5.2-5.3 in Western Africa and Central/Middle Africa

(Tsui, Brown and Li, 2017). The importance of peoples' contribution on the delivery of contraceptives has been recognized by the international community and was reaffirmed at the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt (Bado et al., 2020).

Silumbwe, Nkole, Nzala and Munakampe (2018) state that nearly 14 million unintended pregnancies occur in Sub-Saharan Africa annually, and this is largely due to limited access of contraceptive programmes/services (FP/C). In the European Union, access to contraceptives is easy, for instance, in Spain, the National Health System covers all residents and the service is administered on a regional level by the country's Autonomous Communities (ACs). Both male and female condoms are generally available free of charge or at subsidized prices. Additionally, all pharmacies in Spain are required to provide emergency contraception without prescription and with no age restrictions. Emergency contraception typically costs around 18 Euros, although some Autonomous Communities provide it for free in public health clinics (Centre for Reproductive Rights, 2012). In 2015, it was reported that 225 million women in developing countries would have preferred to delay or stop giving birth, but were not using any method of contraception. Various reasons have been stated for low uptake of these services. They include among others, limited method choices, limited access to contraception, poor quality services, users and provider bias and also gender-based barriers, particularly for marginalized groups like adolescents and the poverty stricken people. The Lancet Commission Report (2018) states that each year in developing countries, more than 30 million women do not give birth in a healthy facility and, more than 45 million have inadequate or no antenatal care.

In Zambia, limited access of contraceptives by married women is 21%; 14% spacers and 7% limiters respectively. The 47% Contraceptive Prevalence Rate (CPR), with difference in rural and urban areas (Silumbwe et al., 2018).

Potasse and Yaya (2021) opine that Uganda is a country that has high birth rates in the world, 5.8 children per woman of child bearing age. An estimated 41% of women living in rural Uganda do not use contraceptives. For the majority of them, limited use occur as a result of lack of community engagement, poor education, financial hardships and

shortages of supply as well as shortage of funding and resource allocation within Uganda's healthcare system. While there are policies in place that give Ugandan women the right to access contraceptives, their poor implementation and lack of accountability is affecting the delivery (Potasse and Yaya, 2021). The rate of modern contraceptives use among youth are low but a staggering 63% of unmarried women between 15 and 19 years old are sexually active, while 43% of unmarried sexually active women between the ages of 20 and 24 years are not using any type of birth control. The overall rate of unmet need for contraception; that is, women who want to either stop or delay pregnancies but cannot get access, is 31% in Uganda.

The limited use of contraceptives has led to an increase in population, unwanted pregnancies, and illegal abortions especially in the developing countries. Developing country like Nigeria has 48% of sexually unmarried women and 19% lacking access to contraceptives. The most commonly used contraceptive methods are male condoms (53.7%), withdrawal (46.3%), pill (21.5%), and rhythm (20.8%) (Turnwait, Agbana, Ojo and Kukoji, 2021).

2.3 Safeguarding Family Planning Service Access in Lesotho

In Lesotho significant steps have been taken and achieved by government and relevant stakeholders in encouraging women to use family planning services. In 1977, only 7% of married women were using family planning services. By 2004 there were148 registered health facilities of which 7 offered family planning services to 35% of women of reproductive age. In 2009, 46% of women were using contraceptives and out of that were 60% of women using modern contraceptives (injections-81%, implants-81%, and pills-61% users). By 2014 family planning services were free and easily accessible in public health facilities increasing women's intake to 63%, (LDHS, 2014). The increase in the use of family planning services in Lesotho has resulted in fertility decline, from 5.81 children per woman in 1971 to 3.5 children per woman by 2004 and 3.3 children per woman in 2014 (LDHS, 2014). According to Lesotho Demographic Health Survey (2014), family planning is part of the Sexual and Reproductive Health Programme of the Ministry of Health and has been an important component featured on the first phase of the National Strategic Development Plan (NSDP I- 2012). The second phase of the

National Strategic Development Plan (NSDP II- 2018/19-2022/23), also has the strategic objective of strengthening disease prevention, promoting equal engagement of men and women in family planning and health decision-making as one of its proposed interventions (Government of Lesotho, 2018).

2.3.1 Commonly used contraceptive methods in Lesotho

There are various contraceptives used and have been discussed below

A) Injectable Contraceptives

Injectables are reported to be easily and consistently available compared to pills (Hubacher 2008). According to LDHS (2014), 24% of currently married women use injectables, a significant increase from that of 2004 which stood at 15%. Rural married women (25%) use injectables the most, while those in the urban areas are at 21%. Eight in ten women (81%) get injections and implants from the public hospitals and clinics. 41% of women in Lesotho receive contraceptive injections.

b) Male condom

Seventeen percent of women (LDHS 2014) use male condoms compared to just 5% in 2004 (LDHS, 2004). The main supplier and distributor of male condoms are government health centres (31%), followed by shops (30%) and friends or relatives (12%).

C) Pill

The pill is not readily available and hardly used, especially in the developing countries. The use of pills increased to 8% in 2014. Six in ten (62%) women obtain pills from the public sector (LDHS, 2014).

2.4 Challenges of Accessing Family Planning Services by Women

Some of the challenges women of reproductive age have faced and continue to face with regards family planning service access include; socio-economic status, cultural adherence and religious beliefs. These challenges often play a role in women not accessing family planning services. Lack of funds to ensure family planning service

delivery, social norms and patriarchy standing in the way of women in receiving contraceptives, limited information and knowledge on use of contraceptives, health provider attitudes, lack of transport and long distances taken to access modern contraceptives are some of the reasons that continue to hamper women in accessing the services.

According to Potasse and Yaya (2021), it is evident that financial hardships faced by women in poor countries result to them not accessing contraceptives, with urban-rural socioeconomic disparities evident. Women of low socio-economic status, specifically in rural areas, are less likely to use contraceptives, therefore having twice as many children compared to families in urban areas. Multifaceted issues such as poverty, access to education, and socio-economic status likely determines a woman's ability to afford access to contraceptives.

2.5 Economic Challenges on Accessing Family Planning Services

Osore (2016) posits that economic factors like residential area; whether urban or rural, or slums versus suburbs, employment status, and educational level may influence the use of contraceptives. For example, women in Kenya who are formally employment reported having regular access to contraceptives, while women in the informal sector of the economy reported that shortage of money prevented them from having access to contraceptives and they had to forgo some of the family planning services they accessed when they could not afford them (Osore, 2016).

2.5.1 High Cost of Contraceptives

The high cost of procuring contraceptives in the developing world affects poor communities most. For instance, the respondents in Luweero community in Uganda, reported that 3000 USh (Ugandan Shillings) paid for one to access contraceptives is not expensive for people living in urban areas as there are likely to afford them because of working or job opportunities available. Contraception use in urban areas is vital as it is far more difficult to raise a large family. Therefore, women residing in urban areas tend to have fewer children. In order to address these challenges of access and use, out-

reach programs were established to extend access to isolated rural communities and provide information and short-term contraceptive methods for (free Potasse and Yaya, 2021). During the outreach programmes by healthcare workers, they provide referral to their clients and keep in contact with them for follow-up appointment and meet halfway those unable to meet travel costs. While some donors not have sustainable means to finance the travel cost of their clients, they may fund the transportation of Village Health Teams (VHTs) for the delivery short-term methods to communities. Added costs included in accessing family planning services comprise; pregnancy tests for clients who have not been using contraceptives for long, STI screening and potential treatment for them and their partner, medicine to manage side effects, and insertion of contraceptives and charges to remove it.

According to Gele, Musse and Shrestha (2020), Somali migrant women in Norway reported they could not access modern contraceptives due to their high cost. Most of them did not work. As a result, they were unable to purchase contraceptives, as they had to use their small stipend (social grant) to sustain their livelihoods. Hulme, Dunn, Gilbert, Soon and Norman (2015) stipulate that the high cost of contraceptives in Canada was cited by women of reproductive age as impeding access to family planning services. Women who cannot afford to access contraceptives are usually not insured. For example, the women shared stories of sacrifice and unwanted pregnancies owing to the cost of contraceptives, especially among adolescents, young adults no longer eligible for youth clinics, immigrants and the working poor. For insured women they were concerned that insurance plans excluded certain contraceptive methods. Quebec's pharmacare plan and many private insurance schemes also excluded the copper intra-uterine device (IUD) on the basis that it was not a drug. Other third-party schemes only covered the intra-uterine system (IUS) for heavy menstrual bleeding, but not for contraception.

African Population and Health Research Centre, Amref Health Africa, Centre for Reproductive Rights and Planned Parenthood Global (2021) report states, for example, that in countries such as Uganda, Burkina Faso, Kenya, Ethiopia and Malawi, most

healthcare facilities remained open though access to family planning services were severely reduced in the beginning COVID-19 pandemic. Healthcare providers and their clients could not travel to facilities due to lockdowns and curfews, lack of public transportation and fear of contracting COVID-19 at the health facilities also contributed to poor service delivery of contraceptives. When services were halted at their usual health facilities, clients were often redirected to other locations. These were mainly clinics and private hospitals that were further away, requiring the use of public transportation or private vehicles to get there. This meant higher costs, as well as delays due to overcrowding in health settings discouraged women from seeking contraceptives. In Uganda and Burkina Faso, for instance, contraceptive users complained about long waiting times and spending an entire day at the health facility due to long lines, which resulted in the loss of daily work and wages. Many women reported that the intersection of barriers such as a lack of money or income, coupled with the increased cost of seeking services (transportation included) prevented them from accessing contraceptives. According to Amiri, El-Mowafi, Chahien, Yousef and Kobeissi (2020), Syrian refugee women in Jordan were not able to use contraceptives because of high cost of accessing them, which also included transport costs incurred when visiting the facilities. Refugees who were not eligible to receive primary healthcare sought services from private clinics and hospitals, which are often viewed by Syrian Refugee women as very expensive and unaffordable.

Financial constraints for Women when Accessing Contraceptives in COVID-19 Pandemic

According to Mavodza, Bernays, Mackworth-Young and Nyamwanza (2022), there were noticeable contraception access challenges that young women in Zimbabwe had before COVID-19; among them the fragile health system and worsening socio-economic situation in the country. For example, CHIEDZA (NGO) providers stated that accessing LARCs at other health programs and clinics were costly for the youths in Zimbabwe. Outside CHIEDZA, the youths faced difficult and limited access of contraceptives because of the high cost of accessing them. These barriers predated the national

contraceptive shortage and COVID-19, with the constraints being made more acute by the pandemic.

In the weeks leading up to the level 5 lockdown during the COVID19 pandemic, CHIEDZA providers tried to inform clients by advising them to come for supplies before the closure, they did this through youth mobilizers. This was done to avoid interrupting contraceptive users and other commodity supplies, hoping that the supplies would last throughout the lockdown period. However, in the days leading to COVID-19 lockdown, other immediate economic concerns arose triggered by the possibility of lockdown meant that visiting CHIEDZA to access contraceptives was not seen as important by the youth. For the regular clients who engaged with CHIEDZA, as the economic stress and turmoil increased, the concerns about their sexual and reproductive health access were replaced by more pressing needs, such as having adequate supply of food to sustain them during the lockdown. For those who attempted to access contraceptives in both the formal and black markets, they were very costly to purchase for many young women. Not only did the youth have less money during the lockdown, but they had become acquainted with the free supplies offered by CHIEDZA as well. According to the youth participants, among those who could not really afford contraceptives, some “borrowed” oral contraceptives from neighbours or peers who had them in abundance. When options were limited, some young women stopped using contraceptives.

According to Hassan, Bhatia, Zinke-Allmang and Shipow (2021), most participants in the study in Kenya reported financial stress and reduced household income during COVID-19 pandemic. The uncertainty and stress linked to the reduced incomes further presented difficulties in decisions about allocating funds to rent, food, airtime/mobile data or family planning. Several women expressed that an implication of this scarcity, for women who wanted to use family planning services but could not afford, was pregnancy. Hassan et al, (2021) further state that with pressure on public health facilities during COVID-19 and the challenges described in accessing family planning services, it was discovered that women sought FP from alternative providers like pharmacies and private clinics as health facilities were focusing on the COVID-19 response. However, acquiring family planning services from different locations also had

cost implications as FP is not free from chemist or private facilities in Kenya. In addition, few women also expressed concern about the quality of FP from the chemists. The additional cost of purchasing FP and the fear of the quality of the contraceptive method complicated the family planning decision for women who sought to use the services. In Indonesian setting, unemployment, poverty and costs were cited as limiting access of family planning services and transportation issues added the problems among multiparous women (Wulandari, Laksono and Matahari, 2021).

2.5.2 Financial Costs in Lesotho

The high cost associated with contraception access is a problem, excluding condoms as they are often freely distributed. Akintade (2010) found that money has been a major issue among many NUL students using contraceptives despite the government subsidizing contraceptives. Patients pay 15 Maloti in government hospitals and clinics; however, not many people afford it. Women residing in the rural areas cannot afford to pay the entrance fee as they are often not working. Transportation costs also prevent most of them to not access contraceptives (Tuoane, Diamond and Madise, 2004).

2.6 Socio-Cultural Norms surrounding Modern Contraception Use

Social perceptions, misconceptions, myths and gendered decision-making have been cited as having contributed to problems faced by women when having to contraceptives. Those from poor households (slums) revealed that fear of infertility is one of the main reason which influences their decision not to use contraceptives such as injections and implants.

Kane et al.(2016) state that in South Sudan, social norms dictate that a woman who does not bear children is considered not worth keeping in a society that also expects men to have many children. Families who do not continue to conceive children are at the risk of being labeled as infertile and subjected to scrutiny; wives specifically are often on the verge of leaving their husbands for other men. Societal stigma in Kabwe, Zambia (Silumbwe, Nkole, Munakampe and Milford, 2018) was cited as impeding access of contraceptives among adolescent girls, healthcare workers were also a major

hindrance for adolescent access and utilization of contraceptives. For instance, adolescents reported that they would rather not utilize the services due to the negative healthcare workers' attitude towards them and the mere thought of community members knowing through the same workers that they are sexually active. Adolescents and unmarried users stated that they were being stigmatized when they were accessing contraceptives as it was deemed only appropriate for adults and married people (Silambwe, Nkole, Munakampe& Milford, 2018).

According to Ahissou, Benova, and Delvaux (2022), socio-cultural factors, gender norms, and religious perceptions about young women in Allada, Benin are influential on whether women should use contraceptives. Sexual intercourse among adolescents is viewed negatively. Early and unintended pregnancy among adolescents attracts negative stereotypes. As a result someone who is sexually active, especially, before marriage is judged and labeled promiscuous. Therefore, single women resort to using traditional methods of birth control (abstinence or fertility awareness) in order to avoid judgments. As a consequence, young unmarried women are barred from using modern contraceptives. African Population Health Right Centre, Amref Health Africa, CRR, and PPG (2021) report, for instance, indicates that women and healthcare providers in countries like Burkina Faso, Ethiopia and Kenya reported experiencing social challenges that limited women's autonomy in receiving family planning services during COVID-19 lockdown. Also, young women had realized that their parents or male partners at home put their use of contraceptives in jeopardy. They had difficulties visiting health facilities because they often had to explain to their parents or partners their reasons for going there, which violated their privacy. The data showed that some respondents, as a result, did not visit any healthcare centre but stayed at home (APHRC, Amref Health Africa, CRR and PPG, 2021).

2.6.1 Decision-Making Power

Osore (2016) further reports that the decisions that were made in households sometimes created problems for women to access to contraceptives. While majority (28%) of respondents discussed and agreed to use contraceptives with their partner,

13% of the women reported that their male partners had refused them to use contraceptives. Therefore, some respondents said their partners were domineering and instructed them to abandon the use, which led to some of them being pregnant in which they ended up doing risky, illegal abortions without their partners knowing.

According to Potasse and Yaya(2021), cultural and religious beliefs were reported to have contributed to women's decline in using contraceptives in Uganda. For example, the women in Luweero explained that, culturally, women were encouraged to conceive until they can no longer do so, and this is in part because many children are desired as this is a way of honouring one's husband, specifically in the rural areas. The beliefs negatively affect women's motivation to use contraceptives.

Kane, Kok, and Rial's (2016) study on women's use of contraceptives in South Sudan's Western Bar el Ghazzal region revealed that younger women participating in the study showed a favourable attitude towards using contraceptives. Not only did they know modern contraceptive options, they were using, despite few that stopped using them after they had side effects such as fatigue and heavy menstrual bleeding. While the women recognized the importance of spacing, there were conflicting opinions on their use. Also men differed on their views about women using contraceptives to space pregnancies. While some men were practical in their approach, others, including some younger men disagreed vehemently. They were concerned about women sneaking behind their backs to use contraceptives, especially, the long-acting injectables. Though not saying it out loud, men implied that the healthcare workers were somehow allowing women to receive family planning services. Due to this trend or behaviour, men barred their wives from using modern contraceptives. Staff in health centres shared their worries on how some men viewed the promotion of contraception use as desperate efforts by outsiders to deny them the right to have many children.

In a study conducted by Gele, Shrestha, Khalif, and Qureshi (2018), women of reproductive age in Mogadishu (Somalia's capital) stated it is very prevalent in healthcare system for healthcare providers to request husband's presence and permission before they can inject the women or give them any contraceptive, except the

Oral Contraceptive Pills (OCPs). This is mandatory in healthcare and this makes choice of modern contraceptives to be limited even when the services are free. The women confirmed indeed health providers require the husband's consent, due to fear that if the husband becomes aware that his wife has received contraception, he may violently confront the doctor who provided the services. In cases where the doctor is willing to provide modern contraception, the doctor often takes an oath with the woman that if her husband finds out that she used contraception, she will not disclose the identity of the doctor who conducted the procedure (Gele et al., 2018).

According to Alrawi (2021), social norms in Iraq still relegate women responsibility to nurturing children, and taking care of household affairs. Half of the women that contributed in the Iraqi Women Integrated Social and Health (I-WISH) national survey conducted in 2020 stated men as sole decision-makers in the home. Just 50% of men had talked about the number of children they wanted to have with their wives, while the wives usually preferred to have fewer children. The conflicts which led to instability in Iraq created more restriction on women as it reintroduced strict gender roles affiliated with Islam within the country. The conflict has worsened leading to high levels of unemployment and poverty which resulted in increased child marriages. The views of husbands in Iraq are extremely important in the decisions pertaining to the use of contraception and many women who contributed in the study said they did not use contraceptives after their husbands made such a plea. Women's choice of contraception is also influenced by the husband's preference. In some instances, women might be denied the right to use contraception by the husband or the mother-in-law. These are commonly reported causes of hindering utilization of family planning services by women across different backgrounds and cities in Iraq. Although no studies on men's involvement in FP in Iraq were identified in the search conducted, the I-WISH survey reported that less than 50% of men have proper knowledge about FP and reproductive health (Alrawi, 2021).

According to Silumbwe, Nkole, Munakampe and Milford (2018), women and healthcare personnel in Kabwe district in Zambia reported that certain religious beliefs were

hampering women to use contraceptives. Religions deemed the women using contraceptives as committing abortion considered sinful. Additionally, offering contraceptives to unmarried women was considered to be inappropriate as it was thought to be promoting promiscuous behaviour and premarital sex in the society. In Bale eco-region in Southeast Ethiopia, women stated that despite their wish to use contraceptives, they could not because of their husbands' refusal. Some of the reasons for refusal included their husbands' wish to have many children compared to what the women wanted, and that using contraceptives was against their religious beliefs. It was also discovered that men opposing the use of contraceptives was due to their lack of involvement in family planning education, information, communication sessions or advocating of contraceptive use in the community (Gonie, Wudner, Nigatu&Dendir, 2018).

2.6.2 Decision-Making Power in Lesotho

Research show that engaging unsafe sex with multiple partners is a major cause of spread of diseases and unplanned pregnancies in Lesotho (LDHS, 2009). Young women in sexual relationships with older men often fail to negotiate safe sex like use of condoms. This imbalance in relationships can lead to negative health outcomes. Mabele (2010) study indicated that in Lesotho, men control relationships which makes it problematic for women to sometimes use contraceptives, as they are scared of being physically beaten, and left to struggle financially, and this problems make women willing participants in their own abuse. According to Mats'umunyane (2011) poor reception of contraceptive use emanate from cultural practices and religious beliefs. Women in Lesotho revealed that fear of stigmatization affiliated with the use of contraceptives by single women discouraged them from seeking the services. They stated that culture is in support of women to engage in sex only when they are married, and virginity on single women is still regarded. As a result it becomes problematic for young people to seek contraceptive services as they avoid disclosing their sexual activities.

2.6.3 Misconceptions about Contraceptive Use

According to Potasse and Yaya (2021), misconceptions about family planning was also found to have circulated deep into the villages in Uganda, posing a significant threat to health workers as women were worried that the contraceptives they are being advised to use will results in infertility, disabled babies, cause cancer or result in death. Diseases like fibroids and other reproductive health complications have been wrongfully attributed to the use of modern contraceptives and this hearsay spread in the community. It was also mentioned that lack of confidence and believe in the government fueled the myths in the community, as members believed the government has a plan to cause barrenness among young Ugandan women and girls. Alrawi (2021), reiterates that in Iraq, wrong information about family planning and contraception use have been stated as dissuading Iraqi women from using contraceptives. Approximately 50% of the non-users in the study conducted in Basra and Mosul indicated that health effects such as cancer and infertility formed the basis for women not to use contraceptives. Many respondents also said they did not receive enough information about contraceptives from healthcare providers. Women attending antenatal care in Erbil reported that they had specific questions about contraception but healthcare providers did not give them sufficient time to address their concerns (Alrawi, 2021). Common misconceptions of contraceptive use by both men and women in Malawi included the belief that contraceptive pills cause uterine tumours, and that the injection causes cervical cancer. Women using contraceptives for long was also said to lead to stillbirths when users get pregnant. They also believed that using contraceptives can lead to low sex drive, with men mentioning that the side effects such as faster ejaculation, frequent urination and backache will be present in a man who has sex with a woman using contraceptives (USAID Report, 2012).

Silumbwe, Nkole, Munakampe and Milford (2018), report that both community members and Healthcare Personnel in Kabwe revealed that myths attached to various contraceptives badly affected the community's use of contraceptives. The myths included concerns that contraceptives could cause bodily harm, impact on future births leading to infertility, sometimes to low sex drive. For instance, some people stated that

using contraceptive oral pill can lead to giving birth to a stupid child in the future, and, a baby with abnormal head. Others told us that contraceptive methods such as CoCs (Mycrogynon 30) and safe plan can be stored in the stomach, leading to fibroids and gastric cancer. Depo-Provera injection is thought to result in infertility. The adolescents claimed that myths were spread by the older people to discourage use of contraceptives among them. For example, they were told that using contraceptives at young age could result in failure to conceive in the future. Amiri, El-Mowafi, Chahien, Yousef and Kobeissi (2020), state that despite availability of contraceptives in a Syrian refugee settlement in Jordan, low use was due to spread of wrongful information regarding the use of different contraceptive methods. The common misconception promoted in the community by physicians among child brides and women is that the Intra-Uterine Device (IUD) cannot be put in the uterine until the woman has had at least 2-3 children.

Diniz, Ali, Ambrogi and Brito (2020), stated that common view about contraceptive use play a role in promoting its approval for use or its refusal in a community. As a result, the communal understanding by young women in Brazil pertaining their concerns about the LARC (the copper intra-uterine device-IUD) available in the public hospitals made them not to use the services. The women who feared IUD insertion justified their fright based on stories they heard in their communities. Most stories have also been about women who contracted chronic diseases such as cancer, or women who got pregnant despite the IUD having been inserted. The women were also scared of putting a foreign object into their bodies and about the copper decomposing inside their womb (Diniz et al., 2020).

2.6.4 Misconceptions about Contraceptive Use in Lesotho

Mats'umunyane (2011) study findings reveal that many people believe that use of contraceptives leads to promiscuity. The belief is most common among men, though, some women share the same sentiment, as they believe that women who make use of contraceptives makes them to be sexually reckless, hence they contract sexually transmitted diseases (STDs), HIV/AIDS and other negative reproductive health consequences.

2.6.5 Religious Beliefs and the Use of Contraceptives

According to Mats'umunyane (2011), no effort has been made to determine the correlation between religion and contraceptive use as available limited literature shows a negative relationship. Hence, the more religious a person is, the less they are likely to use contraceptives. Akintade (2010), found that at the National University of Lesotho 27.6% of respondents cited religion as a contributor to them not using modern contraceptives. Gatsinzi (2006) indicates that religions barely support women to use contraceptive use and fear is instilled in their followers not to use, fearing punishment from God, they abandon using contraceptives. Lesotho is predominantly a Christian country (90%), with most adhering to Roman Catholicism (42%). It was found that religion plays a part in influencing people to not use contraceptives. For example; Charismatic Christians and the Roman Catholic promote abstinence and view it as the proper way to prevent pregnancy among single people and are against promotion of other methods of contraception. While religion has an impact on use of contraceptives, and remains vital in promoting good behaviour on young people such as abstinence by adhering to religious laws and rules (Makatjane, 2002).

Ahissou, Benova, Delvaux&Gryseels (2022) posit that women in Allada, Benin have no power to make decisions on use of contraceptives. Religious institutions, especially the Roman Catholic Church has an influence on the women's utilization of contraception. Women have been made to believe that using contraceptives promotes sexual promiscuity and its use was considered a eugenic procedure. Strong believes in natural methods of contraception contributed to young women's slow pace in welcoming the use of modern contraceptives. The beliefs in using natural methods have been accompanied by the fear on the likelihood of gaining weight, vomiting, menstrual bleeding for long time emanating from using modern contraceptives, and the views have been partially based on hearsay. According to USAID Report (2012), some women in Malawi considered use of contraceptives as committing a sin and were in contrast with the teachings of the Roman Catholic Church and other religious institutions. Constant ridiculing of women who were using contraceptives after having one or two children led to some women to abandon using them. Those against use of contraceptives went

further by accusing women of violating community norms. Women in Uganda also reported that religious beliefs of the Roman Catholic and Muslim communities indicate that God has a plan on the number of children a woman must have, and, using contraceptives was abomination in the eyes of God. Many adherents believed that every child was a blessing from God for the family. This made it difficult for healthcare workers to deliver valuable information on contraceptive use during their community outreach programs. For example, Shanti and RHU indicated their information-sharing efforts were met with doubts and often rejected by Roman Catholics and Muslim communities, this impacted service delivery on a regular basis (Potasse and Yaya, 2021).

Gele, Muse, Shrestha and Quresh (2020) report that the Somali immigrant women in Norway realized that their community frowned on the use of contraceptives because of their religion. Many women reported that they confided their religious leaders on their use of contraceptives but met with strong objection and being urged not to use them instead observe the natural order created by God. The use of contraceptives was deemed controversial among religious leaders, with some refusing it and others welcoming its use. Given the conflicting nature of contraception use among religious leaders, the decision on whether to use or not use contraception was left with the women (Gele et al., 2020). Hulme, Dunn, Gulbert, Soon and Norman (2015), opine that archaic beliefs and biases towards certain contraceptive methods were prevalent among healthcare workers according to women in Canada. Women visiting healthcare centres cited a tendency by health practitioners to give oral contraceptive pills over other methods, even when they were finding it difficult to take the pills daily. Outdated contradictions about birth control methods included women being encouraged to “take break” from hormonal contraception, providing three or six months of contraception prescriptions to encourage frequent reassessments while denying hormonal contraception to all women over 35 regardless of risk factors. There was also a prevalent misperception that intra-uterine devices (IUDs) cannot be used in nulliparous women (Hulme et al., 2015).

2.6.6 Knowledge about Family Planning

Knowledge on contraceptive use was reported to be generally good among Iraqi women (Alrawi, 2021). However, unstable security created by conflicts leading to displacements in Iraq, many women had problems accessing family planning services. Policy implementation that promotes the use of contraceptives among women was also not effective due to lack of resources. This lack of promotion resulted in women not seeking services, and religious institutions discouraged the use of contraceptives. Furthermore, there was lack of advertisement on the social media, leaflets, or other methods from healthcare workers on contraception access. For example, in Iraq's capital, Baghdad, women stated that they had not received information about contraceptives during their visits to the primary health centres. Education on the correct use of contraceptives was found to be limited and needed improvement; some women in Mosul, identified lack of knowledge on the use of contraceptives contributed to them not using them. It is reported that 20% of unwanted pregnancies occurred among women who were not using any birth control method in Duhok and Mosul.

Gele, Muse, Shrestha and Qureshi (2020), state inadequate information on contraception use has been cited as a reason for Somali immigrant women in Norway to not access them. Majority of women mentioned that they get information about contraceptives when they have given birth to many children, who are not spaced appropriately. However, there are some women who had information on accessing contraceptives, but were against its use without any justification. Limited information on contraception use, led women to access wrong information from others. Diniz, Ali, Ambrogi and Brito (2020), indicate that though there is an increase in contraceptive use among women in Brazil, young women were clueless on where to access them, even how to use them. The women stated that they had no confidence on the use of short acting contraceptive methods such as oral and injectable contraceptives, methods commonly recommended and widely used in the Brazilian public health sector.

2.6.7 Correlation between Educational Attainment and Contraceptive Use

Osore (2016) reports that there is a correlation on education level and utilization of contraceptives in Kenya, where 65% of women using contraceptives had at least secondary education. Due to poor education and knowledge of contraceptives, how to use them well and consistently, access to the services was problematic for the women. Amiri, El-Mowafi, Chahien, Yousef and Kobeissi (2020), posit that in a study carried out among Syrian refugee women in Jordan, there was lack of knowledge and awareness on the different birth control methods and their side effects among women and girls. Women with wrongful information on contraceptives were found to have inadequate knowledge and awareness about workshops/support groups that were held for them in their communities. Wulandari, Laksono, and Matahari (2021) mention it became problematic for Multiparous women in Indonesia to have access to contraceptives because of poor education. This supports or build on the studies already conducted, revealing that family planning knowledge and educational status affect the use of contraceptives. Poor education is linked to limited information and knowledge on family planning. Therefore, decisions of using or not using contraceptives among women with poor educational outcomes depended on the husbands' decisions in Indonesia.

2.6.8 Family Planning Knowledge in Lesotho

According to Lesotho's recent Demographic Health Survey (2014), knowledge on the contraceptives is widespread in Lesotho; with 99% of women aged 15-49 years and 98% of men aged 15-49 years having knowledge of at least one method of contraceptives. This increase has been attributed to the role media has played in advertising the use of contraceptives. Women (23%) have heard about or seen messages on methods of contraceptives on the radio, 14% on the television, 12% have read newspapers or magazines, and on 24% saw the family planning information on billboards, pamphlets, and posters. The number of women exposed to family planning messages surpassed that of men for each type of media. The World Bank Report (2022) indicates that in Lesotho women have higher literacy rates (88.29%) compared to their male counterparts (70.1%) which remains critical in influencing women's use of

contraceptives. LDHS (2014) reveals that contraceptive use and knowledge increases substantially with education, for example, 67% of married women in Lesotho with more than secondary education use modern method compared with 38% of married women with no education. Never married educated women use contraceptives in large numbers use compared to those who are not educated and live with partners (Tuoane, Madise and Diamond, 2003).

2.7 Healthcare Barriers

The section includes the health-related problems that prevent women from using contraceptives, as well as treatment by healthcare workers and the distance and time taken to access or make use of these vital services.

2.7.1 Healthcare Provider Attitudes

According to Silumbwe, Nkole and Munakampe (2018), undesirable attitudes from healthcare workers were stated as preventing young women to use contraceptives, specifically marginalized user groups like adolescents. The healthcare professionals in the delivery of contraceptives reported negative attitudes like shouting, scolding, not allowing clients to explain the side effects as driving women away. They prioritized delivering the contraceptives to socially accepted user groups like the married women existed in some of the health facilities. Hulme, Dunn, Gulbert, Soon and Norman (2015) reiterate that in Canada there were medical doctors who did not give contraceptives to specific groups such as adolescents or refusing the services entirely, which was seen as negatively impacting women living in rural parts of Canada.

Gele et al. (2018)'s conducted a study in Mogadishu (Somalia's capital) on women's challenges to access contraceptives. The women explained that the doctors prevented them from using them due to side effects. Several women pointed that they were scared and ha issues regarding contraceptives. Most reported having heard once or on several occasions from doctor detailing that the long time spent by women on contraceptives led to their infertility. In an environment where children are sought, and deemed as giving security for family, the mere information is enough to influence women from using

contraceptives irrespective of its availability. The women also reported doctors as having advised them to use traditional spacing methods, particularly Lactation Ammorhoea Method (LAM), the method which is considered safe and acceptable for delaying or preventing pregnancy. Somali women also showed confidence in using LAM, which made them reluctant to use modern family planning services as per the doctors' advice.

According to Mavodza, Bernays, Mackworth-Young and Nyamwanza (2022), the youth were accustomed to receiving reliable and youth-friendly health services at CHIEDZA but when COVID19 struck and the facility closed, young people were forced to seek contraceptives in public healthcare. Delivering contraceptives like condom became a challenge for these public healthcare facilities, added was fear of poor reception by healthcare workers among young people. The mobilizers reported that young people kept asking them when would CHIEDZA reopen in order for them to access contraceptives. This meant that young women did not return to the public sector clinics and hospitals due to expensive contraceptives, avoided the services entirely, and that the public sector clinics did not view contraceptive services as essential.

According to Hassan, Bhatia, Zinke-Allmang and Shipow (2021), the problems encountered by women when accessing health services in Kenya impacted their ability to link with providers on their decision to use contraceptives. Reasons for this ranged from impediments put by health workers on the number of patients in health facilities accompanied by fear of contracting COVID-19. When women reached a health centre, they had to queue for long, resulting in delays in accessing services. Another way in which women's access of contraceptives was disrupted was due to some facilities allowing consultations to be held via text messages instead of face-to-face interactions. For instance, some women mentioned that health workers chose to provide methods that required less contact with the patients for fear of contracting and spreading COVID-19. Several women also stated that they had to change contraceptive method they were using due to shortages or their limited access. The shortages of contraceptives in public

clinics and hospitals, meant women who did not afford to purchase in private clinics and hospitals did not have access to any.

2.7.2 Healthcare Provider Attitudes in Lesotho

Tuoane, Diamond and Madise (2004) report that in Lesotho, young women were dissuaded from using contraceptives because of provider bias, where healthcare workers would focus on servicing friends before the patients. Adolescent girls stated that accessing contraceptives was not easy due to shortage of birth control methods, and being seen by older people receiving contraceptives at the hospital added to their fears. The Ministry of Health and Social Welfare (2011), detailed that due to lack of funding for training and regularly updating service providers, they can do so little, with some facilities having providers who only give a small range of contraceptive methods even though the facility has infrastructure which allows for distribution of more methods. Badly impacted are long-acting and permanent methods (LAPM), especially IUCDs and implants. Tuoane, Diamond &Madise (2004) further state that majority of family planning service providers had imposed age limit on the provision of contraceptive pills. They gave pills to clients until they reached 35 years after which they recommended that the users switch to another method.

According to Mats'umunyane (2011), contraceptive providers in Lesotho humiliate and are judgemental towards young women who prefer to use contraceptives. Fearing being judged and humiliated, many of these women have decided not to use contraceptives. The services are also not male friendly since most modern contraceptive methods except condom cater for women.

2.7.3 Lack of Transport, Restrictions and Long Distance to Health Facilities

The women in rural areas of Kabwe in Zambia recalled having to walk long distances to healthcare facilities in order to access contraceptives which led their use to decline. These long distances also put clients at risk of being denied access to contraceptive services if they arrived late at the health facilities (Silumbwe, Nkole, Munakampe& Milford, 2018). According to Gonie, Wudneh, and Dendir (2018), women in Bale eco-

region in Southeast Ethiopia cited that they did not use contraceptives due to the long distance between their communities and health facility in which they travelled from one and half hour to four hours in order to access the services.

2.7.4 Transportation Challenges during COVID-19

Mambo, Sikakulya, Ssebufu& Mulumba (2022) posit that in a survey conducted on 724 participants about the problems faced by the youth in Uganda on accessing contraceptives during the lockdown; limited transport in Uganda was reported by 43% of respondents as having affected people's access and use of contraceptives. The long distance travelled in order to access services was another reason that affected young people from receiving family planning services. The high cost of accessing SRH services like contraceptives was another impediment for the youth (26.4% of respondents) and strict curfews imposed by the government also prevented some respondents (24.4%) to access the services. The respondents (22.5%) in the survey revealed that they feared the negative attitude of healthcare providers which influenced their decision not to seek services and a further 21.3% said there was no service provider at the health facilities. School closure was one of the factors that prevented 12.3% of respondents from accessing contraceptives and a lack of information on where to access contraceptives resulted in the respondents not seeking health services during the lockdown.

Legislated measures such as COVID-19 lockdowns, curfews and suspension of public transport passed by the parliament to limit the spread of the Corona Virus, affected peoples' access of health services in both the public and private sectors in Zimbabwe (Muzvidziwa-Chilunjika, Zimano, &Chilunjika, 2020). The non-functioning of public transport, problems acquiring travel documents and limited women's access of contraceptives (Moyo, 2020).

Mavodza, Bernays, Mackworth-Young, and Nyamwanza (2022) posit that when CHIEDZA facility reopened in Zimbabwe, movement that were halted continued to prevent young people to access services. The youth reported that security officers' refusal and harassment also prevented them to get to health facilities. From

nonparticipant observations in the field, the security officers' presence in the streets made young people to fear going anywhere. They were pressed with questions and threatened by the police when they were visiting places like CHIEDZA community centres.

African Population and Health Research Centre, Amref Health Africa, Centre for Reproductive Rights and Planned Parenthood Global Report (2021), the COVID-19 measures put by governments were listed limiting access to and use of contraceptives. According to the report, women and girls in Kenya and Uganda mentioned that prevention of people from moving because of the lockdowns and curfews imposed affected women's access to birth control methods. The consequences of these restrictions added by the small number of people allowed to use public transport at any one time led to a decline in the use of contraceptives. The further a person was from the health facilities, the higher the cost of attaining contraceptive such as transportation costs. The closure of health facilities was said to have limited women's access to contraceptives.

2.7.5 Transportation in Lesotho

The Ministry of Health and Social Welfare Report (2011), Lesotho is a mountainous country with poor road network and infrastructure. It is this reason that prevents healthcare workers from reaching the rural areas, mostly during winter and rainy seasons, making it nearly impossible for women in remote areas to access family planning services. Women (65%) in urban areas were more likely to use modern contraceptives than those in rural areas and are married (57%), this maybe because of health facilities that are very far from the villagers (LDHS, 2014). Health providers stated that in facilities that were set up in communities, some women in neighbouring villages had to trek for at least 30 minutes. Additionally, women in urban areas commuted if health facilities were far from them (Tuoane, Diamond &Madise, 2004). In the mountain region, some clients who had no option of using a horse or car had to walk for six hours to access health services. Where vans were available in rural areas, a single trip for many people was costly (8.50 Maloti -approximately USD $1.36). Mabele (2010)

supports further by revealing that educated women living in urban areas were closer to health facilities and exposed to the media often use contraceptives.

2.7.6 Example of Challenges Women Faced during COVID-19 Pandemic to Access Contraceptives in Africa

It was important to include the challenges women faced when they had to access family planning services during the COVID19 pandemic. Such challenges have been incorporated in this section.

(a) Closure of Non Governmental Organizations Providing Family Planning Services

The COVID-19 lockdown measures slowed the activities of Non-Governmental Organizations (NGOs) in remote areas in Zimbabwe. (Moyo, 2020). The few organizations that were operating between July and August 2020 had to decrease their working hours in the delivery of contraceptives in order for clients to not violate the 6pm curfew (Makoni, 2020). Mavodza, Bernays, Mackworth-Young and Nyamwanza (2022), report that short notice on the closure of CHIEDZA did not give healthcare providers time to meet their clients contraceptive needs. Health provider and youth participating in the study detailed that the rate in which youth was using contraceptives declined during the lockdown. The healthcare providers and the youth agreed that the closure of CHIEDZA, a youth-friendly HIV/AIDS and Sexual Reproductive Health facility for six weeks left young people at the risk of conceiving and contracting diseases.

(b) Shortage of Personal Protective Equipment (PPE) and Fear of Contracting COVID-19

Makoni (2020) states that the Zimbabwe's healthcare was already burdened before the pandemic, with its emergence, everything collapsed compounded by the shortage of personal protective equipment (PPE). This shortage of PPE forced hospitals and clinics where women usually received contraceptives to close as health workers were worried about putting their lives and their patients at risk (Tapera, 2020). The shortage of PPEs also impacted the enthusiasm of health workers in Zimbabwe as 22 000 health workers

were said to have contracted COVID-19 by July 2020 around the globe (Truscott, 2020). This various issues were discouraging women of reproductive age from accessing the services during the pandemic.

According to Mavodza, Bernays, and Nyamwanza (2022), the youth receiving family planning services in CHIEDZA began to be frightened of visiting the facility as they deemed all health care settings to be at the risk of being infested with COVID-19 which could infect them. Similarly, the CHIEDZA Healthcare providers also began getting worried of contracting COVID-19, when commuting in public transport to provide contraceptives to the youth who were visiting CHIEDZA. As a result the quality of family planning service deteriorated.

(c) Stock-Outs and Lack of Reversible Contraceptives

According to Ontiri, Mutea and Stekelenburg (2021), healthcare system in Kenya was constantly stated as a reason which led to decline in the use of contraceptive by women. Shortage or absence of preferred methods of contraceptives forced the women to take alternative methods or leave without one. Also in Kabwe, Zambia, shortage of preferred contraceptive methods and unavailability of long acting reversible contraceptives (LARCs) in some facilities, badly impacted contraceptive utilization as some health personnel had not been trained to provide LARCs methods (Silumbwe, Nkole, Munakampe& Milford, 2018).

While in Burkina Faso healthcare workers mentioned that they did not offer contraceptives (APHR, Amref Africa, CRR and PPG, 2021). This was due to shortage of commodities (stock-outs) and not having health providers offering contraceptives. Some of the workers indicated that they did not offer contraceptives due to lack of commodities, the transmission of COVID-19 in the facility, which led to decrease in the number of people visiting the facility. Similarly, in Uganda, many healthcare providers reported not offering contraceptives (83%) and Comprehensive Abortion Care (74%) services due to shortage of contraceptives; with only few mentioning that the lack of training and shortage of Personal Protective Equipments (PPEs) as their reasons for not delivering contraceptives available to young women. In Kenya, commodity stock-out was also the reason health providers stopped the delivery of contraceptives and CAC

services in some of their facilities (African Population and Health Research Centre, Amref Health Africa, Centre for Reproductive Rights and Planned Parenthood Global, 2021).

2.8 Health Implications of Contraceptive Use

Heavy and prolonged menstrual bleeding, weight gain, fatigue, bloated stomach and low sexual desire are some of the bad health outcomes resulting from using contraceptives by women and will be discussed below.

2.8.1 Side Effects Associated with Contraceptives

Gonie, Wudneh, Nigatu and Dendir (2018), indicate that women in Bale eco-region were scared to experience the negative effects associated with hormonal contraceptive methods and pointed them as a leading basis for the continued decline of the women in using contraceptives. Syrian refugee women in Al-Za'atari camp in Jordan cited side effects such as anger, becoming obese and the "pill weighing on their bodies" as a reason to have stopped using contraceptives (Amiri, El-Mowafi, Chahien,Yousef and Kobeissi, 2020).

Potasse and Yaya (2021) reiterated that the side effects linked with use of modern contraceptives contributed to psychological issues on the clients participating in the study at both clinics in Shanti region of Uganda. The health implications associated with the process of putting loop in the uterus was reported as a valid reason why women were nervous about starting long-term family planning. The respondents from Shanti in Uganda stated rumours such as non-stop menstrual periods, stomach pains, dizziness and headaches as side effects of contraceptives serving as a deterrent for them to not use them. In Malawi, women cited falling ill from using contraceptives like injections, pills and implants. Some had used the modern methods but stopped using because of side effects. Additionally, women had been interested to use contraceptives once they heard about its health implications; they got scared and abandoned the idea.

2.8.2 Side-Effects Associated with Contraception Use in Lesotho

According to Mats'umunyane (2011), young people are obsessed with being attractive which influence their decisions to maintain their appearance. This impact them whether to use contraceptives. Gaining weight is associated with the use of contraceptives, which influence young people to not use them. Health complications such as infertility is linked with the use of contraceptives which makes young women reluctant to use contraceptives.

2.8.3 Domestic Violence

According to Bishwajit and Yaya (2018), domestic violence (DV) poses problems for women to use contraceptives either in direct or indirect manner. Direct manners can include physical confrontation by their partners leading women to not access the services. Domestic violence can also affect women's agency when it comes to exercise her right to access healthcare. In lens of gender equity, the person yielding power in the home has an impact on women's access to contraceptives especially in the setting where domestic violence may be prevalent. This can be detrimental to the decision-making and women's bodily autonomy when accessing contraceptives.

Amiri, El-Mowafi, Chahien, Yousef and Kobeissi (2020), reiterate that violence in the family (Intimate Partner Violence-IPV) is linked to the low usage of contraceptives among Syrian refugee women married underage. These women married as minors had a four times likely to not use contraceptives compared to the women who experienced only IPV. In Kenya, it is a norm for women to use contraceptives secretly because they are not supported by their partners. Some women stopped using contraceptives as soon as intimate partners found out. Incidences of physical violence experienced by wives after spouses discovered they had been using contraceptives further justified their decision to abandon the use (Ontiri, Mutea and Stekelenburg, 2021).

According to Hassan, Bhatia, Zinke-Allmang and Shipow (2021), as a result of COVID-19 lockdowns in Kenya, for example, there was an increase in time spent by women at home, which was not conducive for women who were using contraceptives in secret. Women's interaction with friends and social support groups was curtailed leading to

their decline in the use of contraceptives. Gender-based violence in the home occurred due to financial struggles during COVID-19 lockdowns. As a result, negotiations to use contraceptives for women was linked to violence in the home.

2.9 Conclusion

The chapter discussed the literature review on the challenges faced by women in Maseru Industrial Areas. It explained theoretical framework of the Law of Supply and Demand and its role in contraceptive access. The chapter also included the overview of women using contraceptives in the developing world, Sub Saharan Africa in particular. The socio-economic as well as religious and health-related factors that continue to influence and shape women's use of modern contraceptives in Lesotho have been captured in this chapter. The challenges women faced during the recent pandemic have also been covertly included in this chapter.

Chapter Three

METHODOLOGY

3.0 Introduction

The objective of this study was to find challenges faced by women of reproductive age in accessing family planning services in Maseru Industrial Areas. The chapter also focuses on the research design, study site, population, sampling technique, how the results of the study have been attained and the ethical procedures applied when the study was conducted.

3.1 Research Approach

Qualitative research is a research strategy that put value in words rather than numbers in the collection and analysis of data. It is inductive; rather than begin with an existing theory or hypothesis, qualitative researchers immerse themselves in the natural setting, describing events as accurately as possible as they occur or have occurred and slowly built ground theory (Bryman, 2012). It deals with how individuals interpret, experience, and inteprete the social world (Cleland, 2017). Qualitative research is naturalistic; it attempts to study human actions from the perspective of social actors themselves everyday in their natural setting. It also aims to find root of the problem on hand,

because very little is known about it (Gephart, 1999). The qualitative research method is much more flexible, and it dominates in the density of information compared to quantitative research (Bryman, 1984; Mats'umunyane, 2011), It is mostly associated with words, language and experiences rather than measurements and numbers, Burns and Groove (2003). In finding the challenges faced by women of reproductive age in Maseru, for instance, qualitative method has been used in the study to find the challenges they faced and has enabled the interviewer to explore the research questions relating to the issue.

Case Study

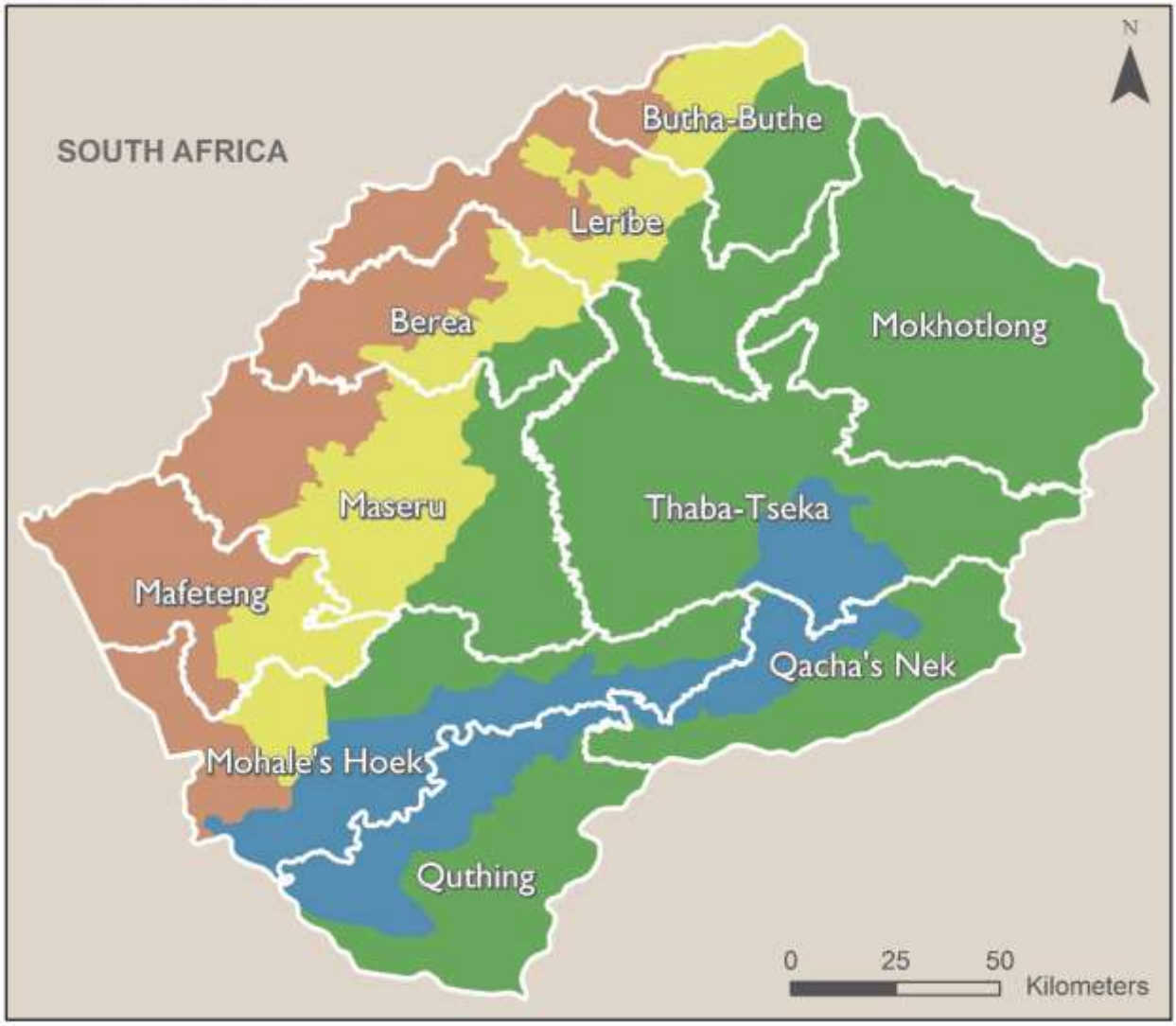
The case study research design has been used to conduct various studies. According to Crowe, Cresswell, Robertson and Huby (2011), a case study is a research design that focuses on single unit to get an in-depth, multi-faceted understanding of a complex issue in its real-life context. It is an established research design used extensively in a wide variety of disciplines, particularly in the Social Sciences as it has a great potential in the development of a ground theory. Yin (2003) defines a case study as an empirical tool that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined. It is useful in situations where contextual conditions of the event being studied are critical and where the researcher has no control over the events as they unfold. The central tenet of the case study is the need to explore an event or phenomenon in-depth and in its natural context (Crowe et al., 2011). Case studies can be used to explain, describe or explore events or phenomena in the everyday contexts in which they occur. Case studies ask the, "how", "what", and the "why" question. It was suitable for this study as it focused on finding out in-depth or greater understanding and insights on the challenges women of reproductive age faced when accessing family planning services using this emic approach.

3.2 Study Site

The Kingdom of Lesotho is situated in Southern Africa and is entirely landlocked by the Republic of South Africa (RSA). It is divided into ten administrative districts; Maseru

(capital city), Berea, Leribe, Butha-Buthe, Mokhotlong, Thaba-Tseka, Qacha's Nek, Quthing, Mohale's Hoek and Mafeteng. The country is about 30 360 square kilometres and has a population of 2.3 million (The World Bank Group, 2022). It is a mountainous country divided into four ecological zones: the highlands (mountains- 59%), the lowlands (17%), the foothills (15%), and the Senqu River Valley (9%) (CIAT and the World Bank, 2018; FAO, 2005). The country lies 1000 meters (3281 feet) above sea level and its lowest point is 1,400 meters (4593 ft), the highest lowest point of any country in the world. Over 80% of the country lies above 1,800 meters (5,906 ft) thus labeled the Mountain Kingdom. Only 25% of the population resides in urban areas while 75% is rural and predominantly dependent on subsistence farming (LDHS, 2014). The study was conducted in Maseru Industrial Areas, as the area has an easy access to many women (20 000) (The Post, 2019) of reproductive age working or looking for jobs in the factories.

LESOTHO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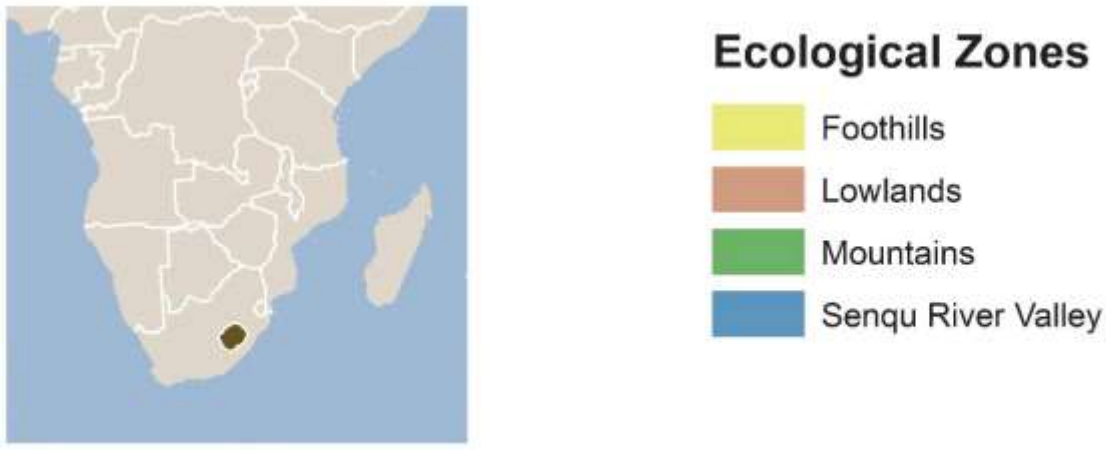

Figure 2: Map of Lesotho

Source: LDHS (2014)

3.3 Study Population

Study population refers to a complete group of individuals or anything of interest the researcher wishes to explore (Serakan & Bougie, 2016: Yaya, 2014). Women in Maseru Industrial Areas were the focus of the study. The study initially focused on young women of reproductive age (18-35 years) even though those above 35 years were also interviewed for inclusivity.

3.4 Sampling

Sampling is a technique used for selecting units that will be observed or studied in a particular research (Babbie, 2016; Adams et al., 2014; Sahu, 2013).Non-probability sampling technique was used in the study. This is a sampling technique in which not all members of the population have a chance to participate in the study. Therefore, non-probability sampling findings are not representatives of the whole population from which the sample was drawn (Showkat and Parveen, 2017).

3.4.1 Sampling Technique

The sampling in qualitative serves as a means of vetting people to find those who can answer the research questions (Huston and Rowan, 1998).Snowball sampling or/ chain referral sampling is a technique which identifies cases of interest from informants who know people that are possess the information required by the research, and, therefore, would be good research participants(Bryman, 2012). During recruitment, as the researcher I approached women who were queuing outside the factories, greeted them and introduced the study to them. Those who agreed to participate approached me (the researcher) few metres from the factory to avoid the noise made by cars and those who were chatting when queuing for jobs. After interviewing some respondents, they encouraged their colleagues to participate in the study.

3.5 Data Collection Method

Face to face interviews were used to communicate with the respondents allowing the researcher to delve in-depth. This enabled the respondents to freely express themselves by conversing back and forth with me. This method is common in the collection of data in qualitative research. In-depth interview (s) allows the researcher to draw some non-verbal communication from the respondent, any uncomfortable behavioural situation that the respondent is in (Serakan, 2003). This helps the researcher to be receptive to changes needed in order to reduce respondents' worries (Mats'umunyane, 2011). My respondents did not show any sign of discomfort when talking about the challenges they faced when accessing contraceptives, they talked openly.

Audio recording is deemed appropriate means of recording data. It has capacity to track trends in speech such as variations in tones and pace of speech often revealing emotions which accompany the words. Face to face interviews allows the researcher to be close and personal with the participants while keeping note of body language (Hughes, 2015).

When doing the interviews, most respondents refused to sign consent forms stating various reasons such as, witchcraft, forging their signatures for illegal activities, not

wanting people to know they participated in the study even when the researcher had told them they could use fake names. As a result, they agreed to consent verbally. Those who wanted to participate were interviewed. There was a woman I came across who stated she was using traditional herb as a contraceptive, I got interested in interviewing her but she declined as she could not explain what the herb was or how it was made into contraception.

Despite few challenges I faced when interviewing the respondents such as resistance to voice-recording which sometimes took time for the participant to be convinced that it was safe for them to be recorded. The participants shared the information willingly and that enriched the findings of the study.

3.6 Data Analysis

Analyzing qualitatively is done to find hidden meanings and patterns of relationships (Babbie, 2016). Therefore, when analyzing data, researchers must select the data analysis methods that will portray a true reflection of the data collected (Sutton & Austin, 2015). Data was analyzed thematically. Thematic analysis is a method that involves reading through data set (such as transcripts from interviews), and identify themes relevant to the study (Braun and Clarke, 2006).

3.6.1 Steps in Data Analysis

During data analysis the following steps were taken;

Step1: Data Familiarization

This step involves reading and re-reading of the data collected as the researcher digs deeper and gets familiar with the content (Lacey and Luff, 2007). After collection, the data is disorganized and no one can make sense of it. It is the researcher's responsibility to align data in a clear and coherent manner for transcription. Transcription means turning data into written form. After data collection, I listened to

audio-recordings and began transcribing the conversations to familiarize myself with the data.

Step2: Organization of Data

After turning the data into a written form, the information gathered is likely jumbled. Researchers must avoid working with unorganized data as this can be problematic when analyzing the data. Re-visiting the objectives of the research and research questions can be helpful in organizing the data. Data should be written in a clear and simple way which allows the researcher to pick concepts and themes easily. This can be done through data that was transcribed (O'Connor & Gibson, 2003).I took information that answered my research objectives and analyzed it in chapter four.

Step3: Coding

Coding compresses data into concepts that can be interpreted for a more effective data analysis. Coding in qualitative analysis comprises of putting data into concepts, properties and patterns. Maguire and Delahunt (2017) report that putting data into codes helps in organizing data in a meaningful and systematic way. Coding reduces lots of data into small chunks of meaning.

Descriptive coding was used and it resulted in getting labels (codes) that identify information appropriate that answers the research questions. Responses that were similar were grouped together and given a code.

Step 4: Searching for Themes

This stage involves reviewing of the codes and comparing data to a broader patterns of meaning. At this stage, the researcher will read the data to identify recurring concepts which align with the research objectives, and classify them into themes. To achieve this, the researcher will immerse him/herself into the collected data to acquire a synopsis of the depth and diversity of the information and, subsequently, identify recurring themes and matters (Adams, Khan, &Raeside, 2014). The codes from the transcripts of the collected qualitative data will be drawn together and present the findings in a clear

manner (Sutton & Austin, 2015).After audio-recording and transcription, I derived themes from the data transcribed which answered the research objectives.

Step 5: Reviewing Themes

If there were themes before, the researcher should look at them and revise them to be certain that each theme has enough data to support it. Themes that are similar are grouped together, and those without enough data to support are removed (Braun & Clarke, 2006). I removed the data that was not convincing enough in addressing the research objectives.

Step 6: Data Validation

The themes are processed by the researcher to make sure that they create a clear pattern and each theme is approved and represents the outcomes of the entire data set (Nowell, Norris, White,&Moules, 2017). This phase is important because it is through it that the researcher can prove the relevance of each element, to see the connections between them, and to guarantee authenticity of the research findings (Labra, Castro, Wright &Chamblas, 2019). In this study similar or related themes were grouped together.

Step 7: Writing Up

This phase involves putting in writing the data extracted and help in making sense of the analysis in relation to the literature. The researcher during writing should be careful to ensure that there is enough information about the research for readers to evaluate its quality. The researcher should present themes using direct quotations of what the participants said to as suggested by Mortensen (2020). The researcher should make sure that the final research report is easy to read and understand to all readers regardless of their familiarity with the topic of study in order to remove misinformation (Labra, et al., 2019; Adams, et al., 2014). The outcomes of the study were summarized to give the reader a clear view of the research that was carried out.

3.7 Trustworthiness

The key standard good qualitative research is guided by trustworthiness, neutrality of findings and decisions. It is, therefore, stated that trustworthiness in research encompases “true value, applicability, consistency and neutrality of the research results” (Rodwell, 1998 cited in Mauldin, 2020).Through the concept of trustworthiness, the studies can gain recognition as the researchers can influence their audience to convince them that the outcomes of the study are worthy of being noiced (Nowell, et al., 2017). After data collection, the researcher took the study findings to the supervisors and they approved the results.

3.7.1 Credibility

Credibility entails prolonged engagement with the subjects, regular observation, tracing and measuring, peer debriefing and member checks (Korstjens& Moser, 2018). Credibility is depicted when research participants’ views and perceptions are commensurate with the findings presented by the researcher (Nowell, et al., 2017). The researcher ensured credible results by forming rapport with the respondents who were able to tell the challenges they have experienced when accessing family planning services.

3.7.2 Transferability

Transferability refers to the notion that the methods used to collect the data can be applicable in other studies and environments(Coghlan and Brydon-Miller, 2014). It seeks to answer issues of external validity and the researcher is obliged to give data and situations that can be used to prove that the research findings can indeed be applied to other scenarios (Cameron, 2011).The researcher does not have to know those who want to use their study findings; however, the researcher is tasked with providing enough information so that those who want to use its findings can use their own discretion (Lincoln &Guba, 1985).

3.7.3 Dependability

In Tobin and Begley's (2004) view in order to achieve dependability, researchers can provide evidence that convinces their audience that the same information can be obtained with the same or similar respondents in the same contexts. When researchers are able to look at the research process, they may draw their own conclusions on dependability fairly (Lincoln & Guba, 1985). Dependability ensures that proper qualitative techniques are followed and that any adjustments that might have occurred during the progression of the study are adequately accounted for, justified, and clearly articulated in the concluding report (Mauldin, 2020). Korstjens and Moser (2018) recommend that in ensuring dependability the study has to have an audit trail, in alignment with the recommendation the researcher securely keeps all the relevant and important documents, transcriptions of the collected data and a notebook with ideas, notes and important dates. Should a need for an audit of the findings arise, the researcher should be in a position to provide all evidence to support that the study was done transparently. The recordings and transcriptions of this study are kept safe for future references.

3.7.4 Confirmability

Confirmability is given the task of establishing that the researcher's interpretations and findings are derived from the data, obliging the researcher to indicate how interpretations and conclusions have been reached (Tobin & Begley, 2004). The principle of Confirmability gives assurance on the degree to which the findings are the products of the focus of the inquiry and not of the biases of the researcher (Treharne & Riggs, 2014).

Confirmability is established when credibility, transferability, and dependability have all been achieved (Guba& Lincoln, 1989). Koch (1994) recommended researchers include makers such as the reasons for theoretical, methodological, and analytical choices throughout the study, so that others can understand how and why decisions were made. The raw data, notes, are available for confirmation and the data analysis of the study has been presented in chapter four.

3.7.5 Peer Debriefing

Researchers may validate the credibility of their research findings through peer debriefing with other researchers (Treharne & Riggs, 2014). Hence, peer debriefing is one of the techniques that can be used in establishing the study's credibility by engaging a disinterested peer who is able to critically analyze and examine factors that may be implicit in the researcher's mind and subsequently raise issues which the researcher might have overlooked (Amin, Norgaard, &Desselle, 2020). In this study, no peer was invited to analyses the outcomes due to the limited time the researcher was left with.

3.8 Research Ethics

Research ethics refer to a set of values, standards, and institutional schemes that help constitute and regulate scientific activity (Kimmel, 1988).

The researcher observed the following ethics:

3.8.1 Informed Consent

Kimmel (1988), described informed consent as a voluntary agreement to participate in a research and is viewed as a contract between the interviewer and the participant. Individuals should be treated with respect and the investigator must ensure that the study subject has an understanding of the topic being studied, the advantages, the risks and the alternatives with the right to ask questions. I showed participants the consent form and read to some of them to understand as they could not read. While some agreed to sign on the form, many respondents refused to do so, citing security reasons (forging signature and misusing it) and fearing the researcher may use their handwritings for witchcraft or illegal things but they did not mind being interviewed.

3.8.2 Confidentiality

Confidentiality is a central issue in all forms of research. It implies that all information revealed by the subject is in confidence and will ensure that confidentiality is kept through limiting information sharing with the research team only and storing the information in the secure place. Polit and Hungler (1999)'s confidentiality entails that

the information that the participant releases is kept secret, unless participants themselves agree to be exposed. By ensuring confidentiality the researcher agrees to not disclose or report private data that identifies the participants. The researcher made a promise to the respondents that the information they gave on voice recordings will not be shared with anyone except the lecturers involved and when the findings are released for the public their personal information will not be shown.

3.8.3 Voluntary Participation

Respondents must not be forced into participating in the study; they should voluntarily do so and must stop participating in the interview any time they wish. The respondents should be given the full intensions of conducting the research; they should not be kept in the dark, (Klenke, 2016). I approached the women who were queuing outside the factories and introduced the study and its intentions and that those willing to participate should follow me as I headed a distant from them at the side road. When they did, I then advised them to come one by one to be interviewed.

3.8.4 Deceiving Subject

According to Lune, Pumar and Koppel (2010), researchers should not use deceptive methods in research by intentionally misinforming the participants about the intentions of the study. Sociologists should not use misguiding techniques unless they have discovered that their use will not harm participants and unless this has been approved by institutional review boards or, in the absence of such boards, another authoritative body with expertise on the ethics of the researcher. The researcher did not deceive the subjects. They were told the intention of the study, and that the information they give will be recorded and released online by The Faculty of Social Science at National University of Lesotho.

3.8.5 No Harm to Participants

Social researchers should never put people under any sort of danger; the interviewer made certain that the participants in this study were not under any danger. The researcher conducting the interviews on these challenges faced by young women of

reproductive age when accessing family planning services did not harm the respondents by forcing them to reveal information they may not want to reveal, including their identity. The researcher was interviewing women who were queuing outside the factories away from their homes. They were free to talk about the challenges they faced and were not bothered by their male colleagues who were outside with them as one respondent shouted and waved at the males to come participate as they laughed it off. They were very open to talk about their experiences and they even showed the researcher a mobile clinic that delivers contraceptives to them.

3.9 Conclusion

The chapter concentrated on the methodological approaches used to address the research questions. This included the research design, site and population. Sampling procedure, data collection methods and analysis techniques were explained in detail. Ethical conduct of the research is also included in this chapter.

Chapter Four

Results and Discussions

4.0 Introduction

The chapter focuses on findings and analysis of the study outcomes. Specific objectives of the study were as follows:

- To examine whether socio-cultural constraints act as a challenge for women's access of family planning services,
- To find economic constraints and
- To explore healthcare providers' attitudes towards women of reproductive age when accessing family planning services.

Themes such as lack of money to buy contraceptives for those using them secretly, community against contraceptives use, the religious and health-related issues that become a challenge for women to use contraceptives have been discussed. The report begins with the demographics of the participants and focuses on findings that led to challenges faced by women of reproductive age when accessing family planning services in Maseru Industrial Areas.

4.1 Demography of the Participants

Table1: Age

Age	Frequency	Percentage
15 – 19	1	6.25
20 – 24	1	6.25
25 – 29	7	43.75
30 – 34	2	12.5
35 – 39	2	12.5
40 – 44	1	6.25
Total	**16**	**100**

The study comprised of 16 female respondents, who were between the ages of 19 and 44. Seven out of 16 women ranging from the ages of 25 and 29 participated becoming the majority in the research as indicated above. Age distribution among the respondents indicates that most are in their prime age of reproducing.

Table 2: Marital Status

Marital Status	Frequency	Percentage
Single	5	31.25
Married	8	50
Co-habiting	3	18.75
Total	**16**	**100**

Marital status of the respondents was relevant to the researcher as it is often deemed a barrier for some people in relationships to use the services. Half of the respondents (8

out of 16) were married and stated that their partners had no issues with them when it came to contraceptive use.

Table 3: Educational Outcomes

Education	**Frequency**	**Percentage**
Primary	4	25
Secondary	9	56.25
Tertiary	3	18.75
Total	**16**	**100**

The education attainment of the participants is recorded above. The study revealed that 9 out of 16 respondents had gone beyond primary school while 3 respondents had or were in higher institutions of learning. Two of the 3 respondents were still in tertiary at the time of the study. Highest education attained by one respondent was Bachelor of Arts with Honours (BAHons) in International Relations from a university in the Republic of South Africa.

Table 4: Occupation

Occupation	**Frequency**	**Percentage**
Factory Workers: Full time Part time	4 3	25 18.75
Hawkers	4	25
Street Vendor (s)	1	6.25
Hairdresser (s)	1	6.25
Tertiary students	2	12.5
Structurally Unemployed	1	6.25
Total	**16**	**100**

Majority of participants (7 out of 16) were workers in Maseru textile industries. Four respondents were street vendors and it constituted the second largest informal sector to employ people. Two participants in the study of 16 participants were tertiary students helping their vendor relatives before their schools opened. One respondent was structurally unemployed and queuing outside the factories hoping to get a job.

Table 5: Religious Background

Religious Denomination	**Frequency**	**Percentage**
Anglican Church of Lesotho	1	6.25
Lesotho Evangelical Church of Southern Africa (LECSA)	4	25
Roman Catholic Church	7	43.75
Christian (Pentecostal)	3	18.75
Atheism	1	6.25
Total	**16**	**100**

In Lesotho Christianity dominates (Mats'umunyane 2010). The study participants were mostly Christians (15 out of 16), except one who was an atheist. When data is desegregated, the majority (7 out of 16) were Roman Catholics while others belonged to different denominations. Four respondents were adherents of the Lesotho Evangelical Church followed by 3 that belonged to Pentecostal/ Charismatic Christian Churches and 1 was Anglican. Most of the respondents reiterated that the religious denominations they affiliate with do not support the use of contraceptives with the Roman Catholics being explicitly clear. Others indicated that their church stance on the use was not clear. Despite the church's disapproval of members using contraceptives, they disobeyed the orders and were using them.

Residential Area

The study has been carried out in Maseru where women working or looking for employment in the textile industries are many and easy to locate. However, only a small sample frame (sixteen women) was used and the findings are not in any way a general view of the whole population.

Table 6: Modern Contraception Methods Used

Variable	Frequency	Percentage
Method of contraception		
Pill (Microgynon)	7	43.75
Injection (Depo)	5	31.25
Condom	1	6.25
Implant	1	6.25
Sterilization	1	6.25
Loop	1	6.25
Total	**16**	**100**

Almost all the respondents stated that they used an injection when they began making use of family planning services but they abandoned it when they had side effects like heavy menstrual bleeding for prolonged times, and weight gain amongst other reasons. Majority of the respondents changed to pills (7 out of 16) such as microgynon which gave them no problems. However, 5 respondents were still using an injection such as depo as a method of contraception. The other 3 respondents used condoms, loop and implants respectively while one respondent who was 34 years old with three children had been sterilized.

4.2 Challenges of Accessing Contraceptives

The challenges women faced included lack of finances to access family planning services and, socio-cultural factors such as the stares women would often be subjected

to when visiting healthcare facilities to get the services. Health-related ones that include heavy and prolonged menstrual bleeding and weight gain as a consequence of using contraceptives have been outlined in this chapter. Responses are quoted verbatim to give the reader what the respondents were saying during their interaction with the researcher.

4.2.1 Economic Constraints for Women to Access Contraceptives

Financial struggles for women, especially those who are young and unmarried (19-24 years), hamper their access to contraceptives in private hospitals and clinics. Some respondents', especially young unmarried women, use contraceptives privately as they do not want anyone within their close proximity to know or suspect that they are sexually active. This privacy of contraceptive use becomes costly for them as they often have to resort to buying contraceptives from private clinics which become expensive for them.

Lisebo, 19-year-old tertiary student, narrated her experiences as follows:

> *I am using the contraceptives secretly as I do not want my parents to find out that I am sexually active. As a result, I have to buy them at the chemist which is expensive. I also have to commute to town to get an injection which adds to my problems as I run out of transport money sometimes.*

Fikile, 25-year-old factory worker, is also quoted below:

> *In the beginning I used to buy contraceptives and this was expensive. I was a bit embarrassed to get them for free at the clinic that is when I decided to get them at the chemist and they were expensive. I stopped using them for few months and had to go get them at the public clinic for free.*

‘Mathato, 35-year-old factory worker, further shared the same sentiments with other participants as quoted below:

> *I used to avoid public clinics and hospitals to access contraceptives, I usually bought them at the chemist and one day when I had to buy them but had no money. I did not get a refill and feared I could get pregnant but opted for withdrawal method which is challenging and unreliable. My partner tried to make ends meet and few weeks later he could not come up with the money and that is when we decided to go get them at the public clinic for free*

Limpho, 27-year-old part time factory worker, stated below on contraception access impediments:

> *I had to buy contraceptives and it was expensive. One can think they are cheap, only to realize later that one needed that money spent on contraceptives to have bought something else. I would find that the money is really not there hence I sometimes needed assistance from my family members including siblings in order to purchase contraceptives at the chemist.*

4.2.2 Lack of Time for Women to get Contraceptives due to Work Commitments is sometimes Costly

Some women mentioned that inadequate time to visit public clinics due to work commitments resulted in them buying contraceptives at the chemist for expensive prices as they are usually the ones opened most of the time, particularly on weekends when they are free.

Mpho, 31-year-old hawker, stated as follows:

> *I always find contraceptives of my choice at the clinic but I feel tired of going to the clinic sometimes because of long working hours at the factory, I buy them at the chemist sometimes. I get one circle at 25 Maloti which is not cheap at all for someone like me.*

Khahliso, 26-year-old hawker, stated as follows on lack of time to get pills:

> *I would sometimes buy contraceptive pills due to me not having time to visit the clinic during the week as I will be busy selling. I cannot leave my things with other hawkers as they can charge me for selling on my behalf and they also steal. I then decide to buy them which is expensive for a struggling person like me.*

4.3 Socio-Cultural and Religious Constraints to Contraceptive Use

The respondents received mixed feeling when they discussed the use of contraceptives with members of their community. This led to some abandoning the use of contraceptives while others, upon hearing their community stance, used the services secretly for fear of being accused of sleeping with boys. Religion also played a role in discouraging women to use contraceptives such that the sentiment was deeply entrenched in the whole community which views a baby as God's gift. This perception forced women to use contraceptives secretly despite the conflicting views they hold. In some healthcare settings women found it difficult to access the services because of patients or peoples' stares at the hospitals and clinics.

4.3.1 Community Influence on Contraceptive Use

Faced with strong community disapproval on use of contraceptives, women sometimes abandon their use to only use them later in secrecy. After using them again they could no longer discuss the use of contraceptives with their community.

'Mankopane, 32-year-old factory worker, became conflicted on whether to use or not use contraceptives because of her community, this below is her testimony:

> *My neighbours are not supportive towards women and girls who use contraceptives. They say that contraceptives will block my fallopian tubes such that when the time comes for me to have another child, I will struggle to conceive. I struggled with this idea and stopped using them for a while until my work colleague advised me to use them. After that I could no*

longer continue discussing the use of contraceptives with my neighbours as they were degrading their users.

Lisebo, 19-year-old tertiary student, mentioned that her community's view on contraceptive use forced her to use them in secrecy. She is quoted below:

My community does not approve of women using contraceptives, they advise young women and girls to not sleep with boys as we will have babies if we do. I have kept my use of contraceptives a secret as I do not want backlash from them, I get the injection at the clinic here in town where no one from my village will see me.

Lack of community support and encouragement for women to use contraceptives creates a challenge for women to make use of them as others may forget their refill when it is time to visit the clinic as they will be hesitant to confide in their family or partners.

4.3.2 Patients and Peoples' Stares at the Health Facilities

Health settings are considered a place where those receiving services are supposed to be free to seek whatever it is they want. However, there are those who may make others feel uncomfortable to seek help in clinics and hospitals. For instance, contraceptive users fear or do not feel comfortable going to the hospital as they are stared at by patients and the people who may make fun of them such that they often have to wrap contraceptive box with a plastic bag to hide from view. Khahliso, 26-year-old hawker is quoted below:

When visiting the clinic to get contraceptives, the nurses were not giving me any problems. However, the people who would be outside laughing and pointing fingers at me when I get out of the clinic holding contraceptive box contributed to me not accessing services on time. They used to scare me and I would find myself needing a black plastic to hide the contraceptive box.

4.3.3 Religion and Its position on Women using contraceptives

The women in the study mentioned their religious beliefs do not approve of women's use of contraceptives. They said that this poses a challenge for them as some use it in secrecy and would sometimes miss contraceptive refill due to them being conflicted over the use. For example,

Lisebo, 19-year-old tertiary student mentioned some of her religious stance on contraceptive use below:

> *I feel guilty for using the injection in secrecy because my family and the Roman Catholic Church are against it. I struggled to come to terms with this when I began using contraceptives; sometimes I did not show up to receive an injection.*

Women who used contraceptives despite the church's stance against it were motivated to do so for economic reasons even when the community view the child as God's gift. It was not enough to convince women to not seek family planning services despite them having to take a difficult decision to use them. For instance,

Fikile, 25-year-old factory worker, stated that

> *The community does not support the idea of women using contraceptives. They say that a child is God's gift, and deserves to be born anytime. But in the current times and economic situation, we use contraceptives. Even our churches are against us using contraceptives but we secretly disobey the culture and the church sometimes no matter how difficult it is for us to come to such a decision.*

4.3.4 Healthcare Providers' Attitude towards Women Using Contraceptives

Young women's decision to receive contraceptives is dependent on the attitude and interaction they have with healthcare providers and their social status in society whether they are married or single. Some respondents, especially young women (19-24) stated

that questions often asked at the clinic when they had to access family planning services discouraged them from visiting healthcare facilities.

Lisebo, 19-year-old tertiary student stated that:

> *I buy the contraceptives from the chemist or private clinic to avoid the humiliating questions the nurses ask me in public clinics and hospital when I go seeking for family planning services. I dislike going there because they ask why a young unmarried person like me is using contraceptives*

'Mathato, 35-year-old factory worker, remembered that in her mid-20s she did not use contraceptives from public hospitals as she feared being asked many annoying questions. She is quoted below;

> *When I was a bit young and not yet mature, I used to not go to public clinics to get contraceptives because those offering the services would usually ask what I was doing at the family planning service section. This prevented me from using free contraceptives when I was younger and unmarried, so I opted to get them at the chemist where there were no personal and humiliating questions asked. At the public clinic, they used to ask us our ages, what is happening for us to be there, you know, those types of annoying questions one was afraid or felt uncomfortable answering when young. As a married woman now, the nurses are very warmly when conversing with us.*

Young unmarried women using contraceptives indicated that for them to continue making use of family planning services, safe spaces should be created for them in public hospitals and clinics. Younger nurses should be given the task of providing family planning services as it may be easier for young women to visit and communicate openly with them unlike when older nurses are tasked with the services.

Lisebo, 19-year-old tertiary student, lamented as follows

> *Honestly, young women like me should be given the services in a respectful manner when they are in clinics. We should not be violated by older nurses when seeking healthcare and this can be achieved if young nurses are put in charge of giving contraceptives to young women. At least one can be a bit free to answer.*

Palesa, 27-year-old tertiary student, indicated that

> *You know, young women may seek family planning services more often if the nurses offering services are slightly their age instead of giving the task to the older ones.*

4.4 Shortage of Contraceptive Method of Choice

Some women indicated that they do not always find contraception method they prefer; sometimes they change the contraception method which can have side effects like heavy menstrual bleeding. Another respondent stated that when their preferred contraception method is not available they end up not using any. Responses are recorded below;

Limpho, 27-year-old part time factory worker, is quoted below:

> *I do not often find the modern contraceptive pill at the clinic. When this happens, I go back home until it is available as I cannot afford to buy them at the chemist. Lately, the nurse advised me to use a loop, I did what the nurse proposed but my body reacts badly to it, I told the nurse to remove it the next time I visited the clinic as I was gaining weight . I once changed from microgynon pills to florin pills and I am now using zinnia tablets*

Palesa, 27-year-old tertiary student, stated as follows on her experience with shortage of pills;

> *One time the clinic ran out of microgynon pills which were fine and I was advised by the nurse to use the ones that are used by breastfeeding*

mothers. I bled heavily every month when it was time for me to menstruate; there was never a time I stopped as I had even small droplets. The nurse would often tell me that it was normal but it was really boring and tiring to always be bleeding, I decided to stop using the pills for a while.

4.5 Health Implications of Contraceptive Use

The women in the study indicated that health conditions that resulted when they were using contraceptives influenced them on whether to use or not use contraceptives. Side effects from using contraceptives such as an injection and intra-uterine device (IUD) include weight gain, bloated stomachs and, heavy prolonged menstrual bleeding as some of the health implications women experienced are outlined below.

4.5.1 Weight Gain

The respondents revealed that as a result of using contraceptives, they gained weight, felt dizzy and became bloated leading to them consulting with healthcare professionals who advised them to change the method of contraception.

'Manthatisi, 38-year-old part time factory worker, stated that:

The first time when I began making use of contraceptives, I was advised to use an injection. The injection used to make me feel dizzy and I was gaining weight that is when I realized it is not a good thing. I was young at the time, which is why I would like to advise young women or girls to not use them.

Fikile, 25-year-old factory worker, as quoted below;

The first time I used an injection, my body reacted badly to it. I used to be bloated. I was sick, when a person pressed their finger on my elbow they could also see that I had gained weight. I switched to Intra-Uterine Device, I began having mild headaches and, I requested for it to be removed.

Lineo, 29-year-old hair dresser, is quoted below:

> *I had been using an injection until 2021 when I changed to pills as I was not menstruating for a long time. The pills made me to gain weight and I dropped them.*

Limpho, 27-year-old part time factory worker, further stated below that:

> *I have used an injection and my body did not receive it very well. There were negative effects on my part. Using an injection made me feel dizzy, I used to vomit, and I also gained a lot of weight.*

4.5.2 Heavy Menstrual Flow (Irregular Bleeding) and Infertility

The respondents reported that when they began making use of the injection, they had heavy and irregular menstrual bleeding which made some of them change the method or to stop using contraception. When some women stopped using contraceptives as they wanted to begin making babies, they faced fertility issues. Responses are written below.

Mpho , 31-year-old part time factory worker, stated her views;

> *When I began using contraceptives, I began with an injection which made me lose weight, I also bled a lot. I stopped going to the clinic to get an injection. After a while I went to the clinic and complained about it. They changed to microgynon pills which have not given me any problems.*

Lisebo, 19-year-old tertiary student, gave her response as follows;

> *I am using an injection which makes me bleed for a long time. I cannot tell people what I am experiencing because I am using this contraceptive secretly. I do not want my parents to find out, they will be furious with me that I am engaging in sex.*

4.5.3 Blockage of Monthly Menstrual Flow

Some women got their monthly menstrual cycle blocked after using contraceptives, specifically an injection. This worried them as they thought it disturbed the natural flow of blood and they stopped getting the injection.

Tebello, 26-year-old hawker, reiterated that

> *I began with an injection, my body reacted badly. It blocked my monthly menstrual blood flow and I did not know what this blockage was doing to my body, this did not sit well with me. If nature made it that women should menstruate every month and here is the contraceptive that is preventing the blood flow, it means a certain body part is not functioning properly. In the end I could have ended up being sick, having waist problems that were never there before I used the injection, so I stopped using it.*

Limpho, 27-year-old part time factory worker, said

> *My monthly menstrual periods stopped as I was blocked and this really worried me. Other people get excited when they miss their period and this is wrong because the uterus has to cleanse itself every month. I also felt dizzy when using the injection; therefore, I stopped using it. I changed to pills which have been good to me.*

4.5.4 Infertility

Some women stated that after deciding not to use contraceptives in order to conceive, they struggled before they could get pregnant while others did not conceive at all. Below is the account of some respondents who had faced infertility issues.

Lineo, 29-year-old hairdresser, responded as follows

> *I stopped using an injection in the middle of 2021 after four years using it. Right now I have been trying to have a baby but the injection is said to*

have blocked my tubes, I am facing infertility issues as a result of these contraceptives and I am really stressed.

'Manthatisi, 38-year-old part time factory worker, mentioned that;

If young women use contraceptives like an injection, it may block them for a long time as it happened to me but I was lucky as I eventually got pregnant. But some women may not be able to have children when they want to as they may be blocked permanently. Even the nurses advise us not to use contraceptives sometimes because they have negative outcomes

4.6 Intimacy Problems and Domestic Disputes

The respondent indicated that after using contraceptives like pills, they lacked the desire to engage in sex and were also tired, which led to disputes with their partners at times. Therefore, other respondents stopped using contraceptives in order to avoid arguments with their partners.

Fikile, 25-year-old factory worker, is quoted below on intimacy issues she faced*:*

I had no sexual feelings towards my partner and this discouraged me from using contraceptives. When one is with her partner and does not get aroused and things remain the same, it is boring for both of them, I stopped using an injection. After few months of hesitating to visit the clinic I eventually went there and expressed my concerns to the nurses and that is when I was given an option to use pills. I have been using them and they have not given me problems like the injection.

Tebello, 26-year-old hawker, stated that

Using depo affected me badly, I ended up having fatigue and my sex drive was low. I was really not happy when time to have sex came.

Palesa, 27-year-old tertiary student, mentioned that

> *Contraceptive use does affect our sex drive; it kills our sexual desire as women. When this happened to me I ended up fighting with my partner as I would no longer be interested in having sex, therefore not satisfying him. This is hurtful, especially when one did not anticipate that by using contraceptives, sex drive will be low.*

'Manthatisi, 38-year-old part time factory worker, stated that

> *The first the injection killed my sexual desire. Then I used pills, things remained the same. I realized that my partner got bored and was fed up at times because of my mood swings and not wanting to be intimate with my partner. I stopped using them.*

4.7 COVID-19 Pandemic Posed a Challenge on Women's Access to Contraceptives

Finding the challenges of accessing contraceptives by women of reproductive age during the COVID-19 pandemic was acknowledged in the study. The COVID-19 spread resulted in poor access or uptake of contraceptives in public and private healthcare facilities due to the lockdowns and curfews that were introduced to slow down its spread by the government of Lesotho. Some respondents stated that prior to the COVID-19 pandemic; they did not face any difficulties in accessing contraceptives at public and private hospitals and clinics. However, when COVID-19 hit, the lockdowns and curfews were introduced by the government of Lesotho in March 2020 when it was declared a pandemic. As a result, women were trapped in their homes and this affected their use of contraceptives. Movement restrictions and curfews imposed limited women's movement which affected their access to vital sexual, reproductive and health services like contraceptives and maternal healthcare. Below are some of the challenges the respondents said they faced when they had to access contraceptives.

4.7.1 Movement Restrictions and Beatings by Security Personnel

Women feared beatings and harsh punishment from the security personnel who were deployed in the streets of Maseru to enforce COVID-19 lockdown measures as per the government directive. Therefore, women who wanted to access family planning services were hampered when they had to abide by the COVID-19 curfews in the first few months of lockdowns in 2020. They found it difficult to get to the clinics and hospitals and as a result, some of them became pregnant with others giving birth in late 2020 while others miscarried and they could not visit hospital to receive maternal healthcare services like counselling after their loss. Respondents like Lipuo, 24-year-old hawker, stated that

> *Before COVID-19 struck, I was using depo injection but when lockdowns and curfews were imposed by the Prime Minister I did not receive the contraceptives at my usual clinic at Sefika Complex. We were instructed not to go anywhere so it was impossible for me to access the depo. I found enormous challenges as I ended up getting pregnant. I was very sad because my life was going to be at risk. The pregnancy was unexpected and when I was finally accepting the situation, I had a miscarriage which was really painful.*

Kananelo, 34-year-old vendor, is quoted below:

> *Before COVID-19 lockdowns I was using pills which I did not access when COVID-19 struck in 2020. I got pregnant as I did not have access to contraceptives because of restrictions and had my third child later in the year. I was then sterilized after giving birth with Caesarean Section and was advised to use condoms instead.*

'Manthatisi, 38-year-old part time factory worker, stated below on her experiences with security personnel during COVID-19 lockdowns;

> *During the COVID-19 lockdowns, we did not manage to visit clinics to get contraceptives as we could not randomly go. The police used to beat us if they found us attempting to go to the clinic to get a refill. If you met with*

them while from the clinic, they would instruct us to lie down on our back, that is when I realized I could no longer manage to get the contraceptives at the clinic.

Tebello, 26-year-old hawker, shared 'Manthatisi's sentiments as quoted below:

I could not go to the clinic where I used to get depo because I could not walk freely like I used to before the pandemic as a result of security personnel being everywhere asking people ridiculous questions.

Vital healthcare services like distribution of contraceptives when delivered at the respondents' doorsteps could have likely averted some of the tragedies the women faced during COVID-19 lockdowns and curfews in 2020. During crises like the COVID-19 pandemic which forced women to not access health services on time, emergency response must be heightened to respond to their needs and that of children.

4.7.2 Closure of Health Facilities

Closing down of health facilities prevented women from accessing contraceptives. The closure of some facilities for a while was as a result of healthcare providers' being afraid and vulnerable to contracting COVID-19 due to limited supply of Personal Protective Equipment (PPE) in clinics and hospitals.

Lerato, 30-year-old hawker, expressed her views on healthcare services during COVID-19 lockdowns below:

The family planning services were not easily accessible before the COVID-19 lockdowns. They were even scarce during the COVID-19 lockdowns and curfews as health facilities were closed in my area due to lack of COVID-19 equipment such as the PPE. We struggled a lot during that time.

Lisebo, 19-year-old tertiary student, mentioned that

> *When I was running out of excuses to my parents to send me to run an errand for them, I visited a clinic not far from my village to get an injection but found out that it was closed. It could no longer operate as funding was limited. The nurses feared contracting COVID-19 as they did not have the Personal Protective Equipment and means of testing people for COVID-19 for the first three months of lockdown.*

4.7.3 Long Queues

The respondents mentioned that during COVID-19 lockdowns the manner in which family planning services and other vital health services offered were different from the ones before the pandemic. As more focus was put to the COVID-19 response, the respondents faced challenges when they had to access contraceptives which affected their usage. Tebello, 26-year-old hawker, stated that

> *Hearing and realizing that the services at the clinic were different from the ones before the COVID-19 crisis, I often was reluctant to visit the clinic. The services changed a lot as we could no longer queue outside the clinic; instead we had to wait outside the property of the clinic. I also feared contracting COVID-19 when queuing on long lines outside in the overcrowded spaces, which made me not visit the clinic to get my refill.*

Fikile, 25-year-old factory worker, expressed her views below on having to queue in what was considered hotspots for COVID-19 transmissions:

> *During COVID-19 lockdowns I decided to buy expensive pills at the chemist because I was fed up with having to be on long queue at the clinic in order to get them. At the time I feared contracting COVID-19 at the clinic which was considered hotspot for COVID-19 transmission.*

4.7.4 Logistical Problems on Contraceptive Delivery during COVID-19 Lockdowns

There are women who began making use of contraceptives during COVID-19 lockdowns and they asked for another contraception method when they realized they were reacting badly to the first one. They could not access another method as clinics and hospitals in which they were receiving family planning services had run out of them and sometimes took long for the contraceptives to be delivered. This prompted some women to stop using contraceptives.

Konosoang, 25-year-old Honours graduate responded as follows on her use of contraceptives

> *I began using contraceptives during COVID-19 lockdowns. I used an injection and I reacted badly to it as I began having blood clots though I did not have my monthly menstruation. When I asked for another method of contraception at the clinic, the facility was not offering any at the time so I ended up not using any contraceptive at all.*

Mpho, 31-year-old part time factory worker, stated some of her struggles during COVID-19 when accessing contraceptives as follows

> *During COVID-19 many people struggled to access contraceptives which led to the increase in pregnancy rates. I also struggled to access the microgynon pills I usually accessed at the clinic as they were not available and sometimes took a long time for them to be delivered. This posed a challenge for me as I had to take the little money I had to purchase them at an expensive price at the chemist to avoid having another baby.*

Palesa, 27-year-old tertiary student, shared some of her worries on contraceptive access below

> *When movement restrictions were imposed I did not access family planning services. I was not fine at all. I still visited the hospital but did not receive the contraceptives because the hospital had run out of*

contraceptives. They also said they were experiencing logistical problems as the Ministry had not paid the suppliers, therefore, they did not know when another batch of contraceptives would arrive.

4.7.5 Fear of Contracting COVID-19 Hampers Access to Services

There are health facilities that were congested during COVID-19 lockdowns in which a respondent reported that she did not seek family planning services at the time as she feared contracting COVID-19 at the clinics and hospitals where the services were being offered.

Khahliso, 26-year-old hawker, gives her own account below

During COVID-19 lockdowns and curfews, when we saw that many people were being infected and dying, we were reluctant to visit the clinics. One realized that visiting a clinic that had many people congested made it easy for COVID-19 to be transmissible, and so I did not go to the healthcare facilities to get the contraceptives for fear of being infected with COVID-19. It was very difficult during the lockdown.

4.7.6 Lack of Privacy for Contraceptive Users Deters their Access to Contraceptives

Some respondents mentioned that there was no privacy for them to make use of contraceptives and visiting the healthcare facilities to get the family planning services, and they could not be open to their parents', especially young women.

Konosoang, 25-year-old Honours graduate details her contraception use below:

I first began using contraceptive pills a month after COVID-19 lockdowns were imposed. Unfortunately, the pills were making me sick and I menstruated nonstop for a while, therefore, I stopped using them. Health effects I experienced influenced my decision to not use contraceptives at the moment and my parents asking me many questions. I was really sick such that I cannot describe it and could not tell those close to me.

Lisebo, 19-year-old tertiary student, also stated her concerns below;

> *During COVID-19 lockdowns we were at home and I could not access contraceptives. I was afraid to go get them fearing that my parents would find out and they would ask where I would be going when schools were shut down. I feared getting pregnant every time I sneaked out to my boyfriend. I also had no money for an injection. When my parents sent me to town to run an errand, I ended up using some of their money to get the contraceptive.*

Young women who use contraceptives had to be discreet in their use as they feared being seen by parents. When they ran out of the pills, they had to find ways to get the money from their parents to buy them. The respondents overstepped their boundaries and used their parents' money without permission to buy contraceptives.

4.8 Conclusion

This chapter highlighted the challenges women faced when accessing family planning services, from have side effects such as weight loss or gaining it, heavy menstrual bleeding, lack of interest in being intimate with their partners, which often lead to domestic disputes, and shortage of contraceptives. The outcomes of the study showed that women did not access contraceptive method of their choice. As a result, some changed to another method of contraception and if they also reacted badly to it, some would not go back to the hospital or clinic to get the services again. Those who used contraceptives secretly found it difficult to access them and to talk about the health effects they were experiencing to their family or those close to them for fear of backlash. This backlash often led to some women abandoning contraceptive use which exposed them to pregnancy. Women stated that COVID-19 lockdowns and curfews put them at the risk of not seeking family planning services due to movement restrictions that were put in place by the government. Even when some managed to visit hospitals and clinics, long queues, congestion and shortage of contraceptives discouraged them from revisiting the health centres.

Chapter Five

Discussions and Recommendations

5.0 Introduction

Discussions and recommendations drawn from the research objectives are presented in this chapter. The research focuses on challenges faced by women of reproductive age when accessing family planning services in Maseru Industrial Areas. The study findings have shown lack of finances, socio-cultural issues such as community's negative view of contraceptive use and healthcare provider attitudes especially to young women as some of the challenges women of reproductive age faced when accessing contraceptives. Side effects as a result of contraceptive use contributed to some women to not continue accessing the services.

5.1 Discussions

The study allowed the interviewer to explore in-depth challenges women of reproductive age faced when accessing contraceptives. The findings show women make use of contraceptives despite the health effects they experience such as heavy menstrual bleeding, gaining weight and the community disapproval of their use. Young women also found it difficult to access contraceptives in public health settings due to stigma associated with engaging in sex before marriage and the judgement they may be subjected to by older nurses. Work commitments by some women made them not to access contraceptives in public hospitals when it is time for refill, so they opted to buying them in private hospitals, clinics and chemists at prices they sometimes cannot afford, therefore, they ended up not using them. The women demonstrated a lot of knowledge on the use of contraceptives. The researcher also realized that the challenges women face when accessing contraceptives seem to be familiar or widespread in the developing countries. The research findings build on the studies that have been conducted before for almost five decades by other scholars engaged in the family planning discourses across the globe.

5.2 Using the Law of Demand and Supply Theory to understand the Challenges Women Face

Borrowing from the language of economics, Serenderowics and Maloney (2022) describe the supply-side of unmet need as the proportion of women with inadequate access of contraceptives among other challenges. The demand-side relating to inadequate access of contraception for women whose non-use is due to less demand leading to low contraceptive usage. In the current study, supply-side of the contraceptives posed challenges for some women. To meet the demand by women using in secrecy for fear of their parents finding out, some resorted to using some of the money that their parents had given them to run errands. Below is the schematic representation of the Law of Demand and Supply Theory which has been used in the study.

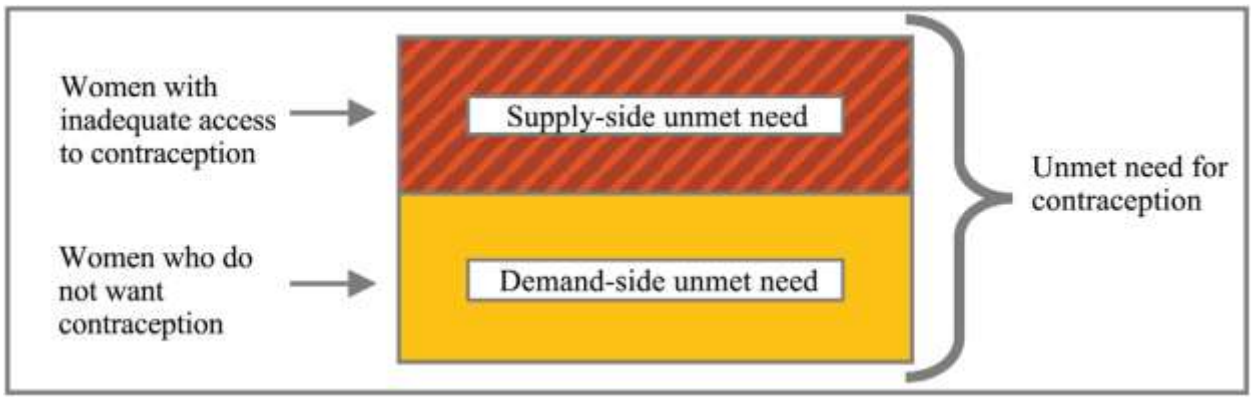

Figure 1 Conceptual Model of Supply-Side and Demand-Side of Unmet Need for Contraception (Serenderowics and Maloney 2022)

Most women indicated that when they began using contraceptives, injection contraceptive was administered and their bodies reacted badly to it resulting in heavy, prolonged menstrual bleeding, weight gain and blocking of tubes leading to infertility in some. When they experienced side effects, many stated that they were allowed flexibility by healthcare providers to change the method of contraception despite others not accessing modern contraception of their choice when they went to seek family

planning services in public clinics and hospitals. Other women in the study mentioned that their communities were sometimes not supporting the idea of women using contraceptives as they believed children should be born as they are God's gift. This attitude made some women not discuss contraceptive use with members of the community for fear of being judged. Young women could also not talk or use contraceptives openly as they feared backlash from their parents should they find out that they are sexually active.

Serenderowics and Maloney's (2022) report revealed that supply-side factors that hindered women's use of contraceptives includes contraceptives delivery issues (modalities), distance, cost, shortage of modern contraception of choice and lack of knowledge on contraceptive use by women of reproductive age, especially those without education. These align with some of the findings in the present study. For most respondents in this study, health facilities were not far from them to access contraceptives; however, issues such as contraceptive shortage for some women, especially in the COVID-19 pandemic, acted as a barrier and sometimes influenced their decision to not use them. High cost of contraceptives in private clinics for young women using them in secrecy made some to abandon the use.

The law of supply-side and demand-side for contraceptive seem to depend heavily on political will, resource allocation, and organizational factors: quality of skills of staff and service, proper health delivery system, access and cost in order to make contraceptives accessible. The delivery of contraceptives should be constant and the government and its development partners should address the above issues in order to meet the needs of users.

5.3 Contraceptive Knowledge

Women in this study had demonstrated knowledge on the use of contraceptives, with condom being most known and used method of contraception. According to LDHS (2014), the knowledge on contraception use is almost universal in Lesotho. Women know that contraceptives like condoms, injections and pills prevents pregnancy and help in child spacing, with condoms likely to prevent people from contracting sexually

transmitted diseases (STDs) and HIV/AIDS. The findings show that conversations around use of contraceptives seems to be widespread among women with those close to them including family and friends supporting their use and even reminding them when they have to go get them from clinics and hospitals.

5.4 Family Planning Service Delivery

This section discusses the summary on the challenges women face when accessing contraceptives. The findings in the current study consider women's use of contraceptives vital in Lesotho as having fewer children seem to be becoming an option in recent times. The research objectives of the study have been summarized below;

a) Economic Constraints for Women to Access Contraceptives

Some women during the interviews stated that work and school commitments sometimes prevented them from accessing contraceptives in public hospitals and clinics, especially during the week when most healthcare facilities are opened. The only time they had time and space to access the services was on the weekends in which public facilities are closed. As a result, most of them had to buy contraceptives in private clinics and hospitals which became quite expensive for them as they earn little in the informal sector of the economy. This led to some women abandoning using contraceptives. Mats'umunyane (2011) states that accessing contraceptives is a problem that people of reproductive age in Lesotho face, with the situation becoming worse for single young women and men. What makes it difficult further for some to access is that government clinics and hospitals in Lesotho open from Monday to Fridays affecting those working and schooling at this time to access services as they have time only on weekends (Mats'umunyane. 2011).

b) Socio-Cultural Constraints to Contraceptive Use

Community's disapproval of women, especially young women, using contraceptives led to some using them in secrecy while others obliged and abandoned their use. Stares by the patients or people at the healthcare settings prevented some women from visiting the clinic or hospitals to get their contraceptives as they felt uncomfortable. Some had to

hide their contraceptive package in black plastic bags, and this does not in any shape or form create a conducive environment for women to feel free whenever they visit the clinics and hospitals which threatened the uptake of contraceptives for some women. Young people used contraceptives in secrecy for fear of being judged. These various challenges women face in Lesotho when making use of family planning services seem to continue to occur in modern times. The findings show that young people are in need of contraceptives but are scared of being seen using them. This is because societal norms dictate that young unmarried women should not be engaging in sex and this limit them to access contraceptives. Studies show that even those who are confident to visit health facilities to get contraceptives, are refused the services in some reproductive health centres; in the case of unmarried adolescents they are required to be chaperoned by their parents (Tuoane et al., 2004). The findings are somewhat similar to those of the study carried out in Namibia where young women according to Indongo (2007) used contraceptives in hiding from both their partners and their parents. Women stated that their parents most of the times had no idea that they were sexually active. Despite the difficulties faced by young women, they had talked about contraceptives with their friends which had influenced their decision to use them (Indongo, 2007). According to Kibira, Karp and Wood (2020), women in Uganda's secret use of contraceptives was as a result of couples dysfunction and gender inequalities. Women ignored the discussions surrounding contraceptives in order to avoid husband refusal.

According to Mabele (2010), in Lesotho men dominate women in relationships leading to problems for women when they have to talk about protected sex. While women's use of contraceptives rested on the decision-making power of men in Lesotho for decades, their influence continue to decline drastically in recent times. In this research, women mentioned that their male partners did not prevent them from using contraceptives. Instead they were more supportive despite their communities' resistance and negative view of family planning service delivery. This is different from findings in countries like Namibia, where men are the decision-makers when it comes to sex as there is still a belief among men that women need their permission to use contraceptives (Indongo, 2007). According to Jonas, Duby and Mathews (2020), adolescents and young women in South Africa stated their parents did not approve of their use of contraceptive. Young

women did not also get support from their male partners and as a result some used contraceptives in secrecy. They reported that some of the reasons their male partners prevented them from using contraceptives was due to misconceptions and myths surrounding the use of contraceptives such as becoming infertile and decreased libido.

c) Healthcare Providers' Attitudes

Women between the ages of 19 and 24 felt uncomfortable and judged by the healthcare providers when they went to seek family planning services. Humiliating questions directed to those women by the older service providers prevented or influenced them to not use contraceptives or to seek alternative providers in private healthcare facilities which are expensive for them. This adds onto Mats'umunyane 2011 findings which revealed those offering modern contraceptives in Lesotho are judgemental and humiliate young women when they want contraceptives. This prevents many young people from using contraceptives because of such humiliating treatment. Tuoane, Diamond and Madise (2004) indicate that family planning service providers in some healthcare centres went as far as putting age restrictions on the use of contraceptives. Mats'umunyane (2011) states further that family planning services in Lesotho are not catered to young people's demands as humiliation and being turned away by some health service providers remains a norm. The shortage of choice on contraceptives also impedes access. The available methods are usually male condoms, pills and injections, suggesting that users choose from a small number in public health facilities and this influences young women to seek services in chemists. The remaining issue, is that it must be prescribed for the women to receive the contraceptives (Mats'umunyane, 2011). In Namibia, it was observed that young women have problems using contraceptives due to bad interaction between older nurses and young women. The findings showed that young women are not open to talk to older nurses when seeking contraceptives as the nurses did not understand or realize and protect the rights of younger women by providing the services ethically (Indongo, 2007). In South Africa, adolescents and women stated that the negative attitudes by health service providers created a barrier for them to make use of contraceptives. They said that the nurses

shout at them because they are too young to be using contraceptives and humiliate them by questioning them in front of everyone (Jonas et al., 2020).

On positive note, the study revealed that health professionals, for the most part, are supportive and conversant when married women seek family planning services in clinics. They engage and advice breastfeeding mothers to use contraceptives to prevent them from getting pregnant without child spacing. This warm reception has made the women to continue using contraceptives. Indongo (2007) states that married women in Namibia were very comfortable and openly visited health facilities than single women. Family planning services, counselling and information services were easily at their disposal.

d) Health Outcomes of Contraceptive Use

The respondents stated that weight-gain, dizziness, heavy menstrual flow, nausea and infertility are some of the illnesses they had after using contraceptives like injections and pills. These various negative outcomes influenced some to opt for other methods of contraception or abandon the uptake entirely. The results are supported by previous studies conducted in which respondents have cited prolonged and irregular menstruation, weight gain, stomach aches, dizziness and fatigue as some of the reasons women abandoned using contraceptives (Gonie et al., 2018). Despite negative use of contraceptives in some women, there are young women, especially those out of school in Namibia, who supported the use of pills and injections. They said injection was convenient as no one would notice when a woman is using it and that one does not have to be reminded to take a pill or carry condoms every day, and also no one can be sexually stigmatized (Indongo, 2007).

In Lesotho, young women cited that using contraceptives makes them develop pimples and causes menstrual irregularities and fear of being infertile prevents them from seeking family planning services. Even those open to using contraceptives decline due to side effects attached to use like weight gain, and contracting sexually transmitted diseases (STDs). People also feared that contraceptives would led women to behave to recklessly (Mats'umunyane, 2011). Indongo (2007) reports that in Namibia, young

women in school preferred using condoms as a method of contraception. They used them due to them being easily available, affordable and vital in disease prevention and unintended pregnancy. Unlike hormonal contraceptives, condom does not lead to infertility.

5.5 The Impact of COVID-19 on the Delivery of Family Planning Services

During COVID-19 lockdowns imposed by the government of Lesotho in 2020, movement restrictions were imposed to curb the spread of COVID-19 which impacted on women's access of contraceptives.

a) Human Rights Violations by Security Personnel

The findings indicate that most women did not have access to contraceptives as they feared security officers torture and punishment should they visit the clinic and violate the lockdown restrictions and curfews. The outcomes built on the literature review on the challenges women of reproductive age faced in countries like Uganda and Zimbabwe. For instance, in Zimbabwe, COVID-19 lockdown and curfews imposed prevented women from accessing contraceptives as public transport was halted. Young people reported military or police resistance and harassment as some of the contributing factors to them not accessing family planning services in CHIEDZA health facility (Mavodza et al., 2022).

b) Fear of Contracting COVID-19 in Hospitals and Clinics

Women hesitated visiting clinics and hospitals to access contraceptives as they feared that they were hotspots for COVID-19 transmission. Long queues and limited number of people that were allowed into the clinic and hospital discouraged women from getting their contraceptives. The findings also state that there were mobile clinics during COVID-19 lockdowns which enabled some women to receive contraceptives in bulk. However, for young unmarried women living with their parents, visiting chemist or clinics to get contraceptives was a challenge, as they could not tell their family members openly that they were going out to get them as contraceptive use and engaging in premarital sex is still considered a taboo in Lesotho.

c) Contraceptive Shortage

The clinics and hospitals also ran out of contraceptives which made it difficult for women to go back for a refill when family planning services were scheduled for another date. Some opted to buy them from the pharmacies which were expensive as others were laid off from their jobs in the textile industry when COVID-19 lockdowns and curfews were introduced. In Kenya, poor healthcare service contributed to women not using contraceptives. Shortage of their preferred method of contraception also influenced their decision to take alternative method or leave without getting the services (Ontiri, Mutea and Stekemenburg, 2021).

Recommendations

- Women in the study strongly recommended that young women without children should not use contraceptives except condom as they affect their bodies negatively sometimes leading to infertility, bloated stomach, obesity, low sex drive and dizziness. There should be clear explanation by healthcare professionals on both the positive and the negative consequences of using contraceptives.

- Family planning services or sex education should be introduced in secondary schools because that is where majority of young people begin engaging in sex. We should also engage religious institutions in the development of sex education curriculum as they are the ones that own 90% of schools (Nkanda, 2017) in the country. Including the churches in the curriculum is important because they are against the use of contraceptives. Engaging them in this discourse is vital for the government and development partners in equipping and spreading awareness to adolescents and teenagers on the importance of modern contraceptives.

- During pandemics like that of COVID-19 which caught people off guard, healthcare professionals or people from the concerned ministry in the country should introduce mobile clinics throughout the country so that health services like that of contraceptives are delivered at people's doors all the time. Mobile clinics will also cut women's unnecessary spending even post-COVID-19 as they will

not waste their money on buying them at the chemist due to some not having time to visit clinics and hospitals because of work commitments.

- The HIV/AIDS transmission on adolescent girls and young women (15-24 years) in Lesotho is very much higher (14.2%) than (0.13%) of adolescent boys and men aged between 15-24 years (Schwitters, McCracken & Low, 2022). Young women are clearly engaging in sex in the country. Therefore creating a conducive environment for adolescent and youth friendly health services such as contraceptives in public clinics and hospitals would come in handy as it will reduce high prevalence of pregnancy, abortions and HIV/AIDS transmission in the country as they will make use of family planning services if those delivering the services are not judgemental.

- The government should strengthen the Community Health Care response both in urban and remote parts of the country so that family planning services are accessed by all, including people with disabilities (PWDs).

5.6 Areas for Further Research

- The relevance of the findings builds on the already existing literature on the history of contraceptive access by women in Lesotho. What remains clear is that the society is not yet accepting young women engaging in pre-marital sex. This is reflected in the way young women in the study indicated their discomfort in getting contraceptives from public clinics and hospitals. They would rather find means of having money to buy contraceptives from private clinics and hospitals just to avoid humiliating comments and questions often asked by those in public healthcare service. Research can also focus on health professionals' attitudes in dealing with family planning issues especially towards young women who make use of the services.
- The study also reveals some shortfalls when it comes to the delivery of contraceptive during crisis; for example, COVID-19 pandemic related lockdown and curfews disrupted the use of contraceptives for some women.

- Due to movement restrictions in the beginning of the COVID-19 outbreak in March 2020, some women did not access contraceptives and they fell pregnant and some ended up having miscarriage as they could not access health services. Strengthening health emergency response in humanitarian crises should be a priority in the country.

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Appendix A Informed Consent

Khotso ‘M’e. My name is ‘Mafumane Jane Lephoto. I am in my final year in a Master of Science in Sociology (specializing in Health and Medical Sociology) at the National University of Lesotho (N.U.L). I am doing a research on the challenges faced by women when accessing contraceptives in Maseru Industrial Areas. The study intends to examine whether socio-cultural constraints are a barrier to accessing family planning services and understanding the economic constraints young women of reproductive age face in accessing family planning services. Please kindly allow me to interview you on the topic.

The information you shared during the interview is strictly confidential and will be used solely for academic purposes. The interview will be 20-30 .

The voice recordings will be used to preserve the information provided during the interview so that everything said will not be forgotten, but should you feel uncomfortable being audio recorded, I will pause the interview. I will take notes while we talk. The audio recordings and notes will be kept safely and upon completion of the study they will be destroyed.

For further questions contact for my supervisors at the National University of Lesotho (NUL) will be given.

Appendix B Interview Guide

Demographic Information

1. When were you born?

2. Where do you reside?

3. Marital status

4. Level of education attained?

5. What do you do for a living?

6. Are you religious?

- Which religious denomination do you affiliate with?

Family Planning Sources and Methods

7. What have you heard about contraceptives?

- Including rumours, myths (where did you hear?)

8. What is your opinion about contraceptive use among young women?

9. Have you considered using or ever used contraceptives?

- What were your reasons for using?
- When did you begin making use of contraceptives?
- Are you still using them?

10. How did you feel when you started using contraceptives?

- Which contraceptive do you use?
- How did you decide on the method you are using?
- How would you rate it?

Family planning Access Challenges

Socio-Cultural Barriers

11. Are people in your life supportive about your use of contraceptives?

- Please explain
- How does that make you feel?
- If they are not supportive does this pose a challenge for you to use contraceptives? How?

12. Does your cultural practice endorse your use of contraceptives?

- If no, how does its use affect your culture?
- Has this affected your use of contraceptives? If yes, please explain

13. Does your use of contraceptives contradict with your religious beliefs?

- If yes, please explain the contradiction?
- Has this affected your use of contraceptives? If yes, please explain

14. Have you talked about using contraceptives with anyone?

- Whom did you talk to?
- How did the conversation come about?
- If you can recall, how did they react?
- How did the reaction make you feel?
- Would you tell other people?

15. Has contraceptive use affected your sex life?

- If yes, how?

16. What worries if any might you have about using contraceptives?

Economic Barriers

17. Have you ever faced any financial constraints when seeking contraceptives? If, yes

- Please give me details of what happened
- What did you do

18. Do you always find the contraceptive method of your choice available where you get them?

    - If No, how does this affect your use
    - What do you do to meet the shortage?

19. Have you ever considered visiting health facilities to get the services?

- Please tell me about it

20. Is the place where you access contraceptives close by?

- If yes or no, how does this affect your intake?

Healthcare Provider Attitudes

21. How do you feel when visiting heath facilities to get the services?

22. Do you have to interact with healthcare providers to get contraceptives? If yes,

- How is the interaction?
- How does it make you feel?

23. How are the healthcare providers' attitudes when you seek family planning services?

- How does their attitude or response make you feel?

Health Challenges

24. Have you ever had side effects as a result of using contraceptives? If, yes

- Can you explain in detail the side effects you developed?
- Has this affected your usage? How

25. Has the contraceptive you use been useful?

- Can you explain

26. Do you have anything else you would like to share with us about use of contraceptives?