

## RESEARCH REPORTS

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# *Family planning dialogue: Identifying the key determinants of young women's use and selection of contraception in Namibia*

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### **Background**

Irrespective of the overriding socioeconomic and political milieu, young women in the age group 15-24 years are recurrently exposed to sexual and reproductive health risks and infections, as well as unintended pregnancy and childbirth (Mfono 1998; Al Azar 1999; Meekers & Klein 2002; Creel & Perry 2003; Prata et al., 2005). The acknowledgement that young women are 'at risk' of unplanned pregnancies, or are 'vulnerable' to infections, has invited much research into the social and demographic dynamics of this life phase and to the devising of programmes to address reproductive health agendas. UN reports (for example, World Youth Report 2003; UNFPA 2004) indicate a global decline in unwanted teenage pregnancies, but a high proportion, nonetheless, of premarital births still occurring among young women who are economically and emotionally ill-equipped for motherhood (Creel & Perry 2003). Facilitating young women's abilities to take charge of their sexual and reproductive health would be central to reducing unwanted fertility and to improving their general situation in society.

Studies of African fertility have shown that significant proportions of young women, who endure unintended pregnancies, have had no or poor education on the topics of sex, contraceptive use or reproductive health in general (Muhwava 1998; Burgard 2004). Several researchers have emphasised the urgency for accessible family planning information and services for sexually active young women – in particular, services that demonstrate confidentiality and convenience (Abdool et al., 1992; Agyei & Migadde 1995; Khan & Rahman 1997; Karim et al., 2003). If young women are to use contraception effectively and consistently, it is further argued, they must encounter more encouragement to do so from their peer networks, adults generally and the mass media. Additionally, existing services need to be regularly scrutinised to assess

whether they are meeting the varied demands of young women (Hersh et al., 1998; Juarez 2002; Creel & Perry 2003).

Substantial evidence is found in the literature for how broadening the choice of contraceptive methods results in increased overall contraceptive prevalence (Magadi & Curtis 2003; Chen & Guilkey 2003). The provision of a wide range of contraceptive methods increases the opportunity for individuals to obtain a method that best suits their needs (Ross et al., 2001). Apart from health service requirements, young women, as anecdotes suggest, need the finer negotiating skills to mediate decision-making in sexual relationships. Many do not feel comfortable discussing sexual or reproductive issues with parents or other adults in responsible positions (for example, teachers or health care workers) (Meekers & Ahmed 1997; Whitaker et al., 1999). Likewise, these authoritative figures are often unwilling or unable to provide comprehensive, accurate, age-appropriate reproductive health information to young people. This is partly due to their discomfort in discussing the subjects of sex or reproduction or to the erroneous view that providing any information on these topics will encourage increased sexual activity (Karim et al., 2003). Because of such factors, many young women enter into sexual relationships with insufficient insight into the consequences of sexual encounters and with limited knowledge of protective measures against pregnancy. Whilst these are general problems, and not unique to the Namibian situation, they are of particular concern in the post-independent era where health, sexual and reproductive services are being revamped for a largely youthful Namibian population.

For non-Namibian readers the following brief remarks about Namibia's social and economic background might be useful. Namibia is the most arid country in sub-Saharan Africa. In the western border of the country lies the Namib desert, to the south, the Kalahari. Despite its harsh climate, close to half of Namibia's approximately 1.9 million people earn a living through agricultural production (Central Bureau Statistics (CBS) 2003; Ministry of Health and Social Services (MOHSS) 2003; National Planning Commission (NPC) 2006). Much of the land on which agricultural activity is pursued remains in the hands of several thousand white farmers, a situation that has since mid-2004 ignited processes of redistribution and restitution (NPC, 2006). At the end of the nineteenth century, the Germans colonised the country, setting up infrastructure to access newly discovered diamond and mineral mines. After the First World War, South Africa was given the 'guardianship' of South West Africa, as Namibia was called, and encouraged white settlement by giving title to land for commercial farming in the central and southern areas. This setup has structured highly inequitable income distribution levels. Today unemployment is high, and approximately 47 percent of the population is living in poverty (CBS 2003; NPC 2006). In such circumstances, where large numbers of people endure poverty, women's health usually suffers and their ability to access good quality services becomes more of a challenge (Buvinic 1998; Oxaal & Cook 1998; Shapiro & Tamashe 1999).

Namibia inherited a health system that was segregated along racial lines and based entirely on curative health services. Shortly after independence major changes occurred in all sectors and many of them were drastically restructured to meet the challenges of the post-apartheid era. The government of Namibia committed itself towards ensuring the equitable distribution of resources and accessible basic services

for the disadvantaged (NPC 1997). In 1992, two years after Namibia's independence, the first ever Namibian demographic and health survey (NDHS) was conducted. It was conducted at a stage when a large-scale re-organization of Namibia's national health service was occurring and most primary health care programmes were being established. The 1992 NDHS results revealed that only 23 percent of Namibian women were using contraceptive methods. This percentage changed quite significantly by 2000; the second NDHS survey results show that the contraceptive prevalence rate had increased to 38 percent (MOHSS 2003). The overwhelming majority of current users employ modern contraceptive methods (more than 97 percent) while traditional methods have dwindled into relative insignificance. The survey also shows that while most young women in Namibia are aware of HIV/AIDS and the risk of pregnancy, they are still engaging in unprotected sex.

Prompted by calls emanating from the 1994 ICPD Programme of Action, the Namibian government introduced a reproductive health and family planning programme with the overall objective of promoting, protecting and improving the health of family members, especially women and adolescents. Currently, young people's reproductive health and development represents one of the 'priority areas' of the Ministry of Health and Social Services (MOHSS 2001). Whilst there is no detailed or separate policy on adolescent and youth-friendly health services, the reproductive health programme of the MOHSS is actively targeting the youth to consider their health service needs. In addition, the national school health policy under the Ministry of Education is addressing problems associated with the general health of school-going children and is promoting the development of programmes on life skills and sexual health education (NPC 2000; MBESC & MHETEC 2003).

Against this background of increasing action in the national health domain, there is much curiosity about young women's access to, use and selection of contraception. Specifically, the following research question is addressed in this article: *What are the socio-demographic determinants of contraceptive use and method choice among young women in Namibia?* Whilst this research question is a basic one in demographic and reproductive health studies, it has yet to be provided with a definitive answer in the case of Namibia. We address the question through the use of both quantitative and qualitative methods.

## **Quantitative and Qualitative Methods**

### *The Namibian Demographic and Health Survey (2000)*

At the time of writing, the 2000 Namibian Demographic and Health Survey (NDHS) offered the most recent and accessible dataset with information on contraceptive use and young women's choices in respect of contraceptives in Namibia. The survey included a total number of 6755 women, aged 15-49 years; a subset of this group was drawn for study and analysis. Young women (15-24 years old) who were exposed to the risk of conception at the time of the survey, that is, those who were not pregnant at the time of the survey, were selected. This reduced the sample to 2576 young women. A smaller number of young women (1776) described themselves as 'sexually active'. This group was selected as the particular unit for study. Table 1 shows the age distribution of all non-pregnant young women in comparison with the non-pregnant sexually active group of young women.

**Table 1: Age distribution of young women (15-24 years)**

| Age group    | All women   |            | Only sexually active women |            |
|--------------|-------------|------------|----------------------------|------------|
|              | N           | %          | N                          | %          |
| 15-19        | 1380        | 54         | 695                        | 39         |
| 20-24        | 1196        | 46         | 1081                       | 61         |
| <b>Total</b> | <b>2576</b> | <b>100</b> | <b>1776</b>                | <b>100</b> |

(Source: NDHS, 2000)

### *Methods of quantitative analysis*

Two related processes, viz., the decision to practise contraception and the choice of method determine the prevalence of a specific contraceptive method. Therefore, these processes are modelled here in two stages. In the *first* stage the determinants of the decision to use contraception are examined. This analysis is based on data gathered from the 1776 young women who were identified as 'ever sexually active' in the NDHS. Contraceptives, by definition, are used for the purpose of limiting, preventing, delaying or spacing births (MOHSS 1995). Thus it is sufficient to consider young women who are sexually active but who are either users or non-users of contraceptives. The determinants of contraceptive use are therefore modelled using a binary logistic regression. It was chosen as the most suitable method because of its ability to detect changes in measurements that are brought about by addition of new variables to the equation. In logistic regression the dependent and independent variables do not need to have a linear relationship and data for variables do not need to be normally distributed. The results of the logistic regression models are converted to odds ratios, which represent the effect of one unit change in the explanatory variable on the indicator of contraceptive use. Odds ratios larger than one (1) indicate a greater likelihood of contraceptive use than for the reference category; odds ratios smaller than one (1) indicate a smaller likelihood compared with the reference category.

The relevance of a particular independent variable as a predictor of contraceptive use can be determined by comparing the magnitude of the regression coefficient with that of its standard error. Evidence of the usefulness of the independent variable becomes apparent if the coefficient is much larger than its standard error. The overall form of the model was determined by the square of the multiple correlation coefficients between the dependent and independent variable ( $R^2$ ), measuring the percentage of variation explained by the variables. The models assumed no relationships between the independent variables. The models were fitted to the data using backward stepwise procedure, where the full model was fitted but at every step, terms already in the model were checked to see if they were still significant. To test whether a variable is significant the t-value was produced for each variable coefficient. The value was used to test whether any levels of categorical variables could be combined or whether any term of categorical variables should be removed from the model. The 5 percent significance level was used as a basis for deciding if a particular variable should be retained in the model. In all cases a reference category was chosen. The models were interpreted in terms of the odds ratios. The odds ratios are generally obtained by taking the exponential of the parameter estimate ( $e^b$ ) and used to compare odds between two groups.

The logit model is of the form

$$\text{logit}(p) = \log\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1 x_1 + \dots + \beta_k x_k$$

The odds of using contraceptive methods can equivalently be determined in terms of probability of current use,  $p$ , as

$$p = \frac{\exp(\beta_0 + \beta_1 x_1 + \dots + \beta_k x_k)}{1 + \exp(\beta_0 + \beta_1 x_1 + \dots + \beta_k x_k)} = \frac{1}{1 + e^z}$$

where  $z = \beta_0 + \beta_1 x_1 + \dots + \beta_k x_k$

In the second stage, determinants of the choice of methods among sexually active young women who are using contraceptives are examined. The interest here is on examining which method is preferred by young women, why it is preferred and what the characteristics of young women are who are using a specific contraceptive method. The response variable is choice of method among the commonly used methods in Namibia (the injection, male condom, pill and other methods). The determinants are modelled through the multinomial logistic regression using injection as a reference category. The multinomial logistic model is of the form:

$$\log\left(\frac{P_j}{P_J}\right) = \sum b_{jk} x_k$$

and this can be interpreted as the logarithm of the ratio of the odds of an individual belonging to category  $j$  for  $j = 1, 2, \dots, j-1$ , to the odds of being in the reference category  $J$ . In applying the multinomial logistic model to contraceptive method choice, it is necessary to point out an assumption of the model: the assumption of mutual exclusiveness and exhaustiveness of the choices women make. This did not pose a serious problem as women who used more than one method concurrently were able to indicate the method that they mostly relied upon. All analyses were performed using SPSS.

#### *Qualitative Methods: Focus Group Discussions*

A select number of focus group discussions were conducted in 2004 to build additional and nuanced understandings of young women's attitudes towards health service utilisation, contraceptive use and contraceptive method choice. The data drawn from focus group sessions are regarded as supplementary to the survey data, to further illuminate the statistical findings. Most surveys, including those used in demographic and health studies, offer detailed but snapshot overviews of sexual and reproductive behaviours (Caldwell 1985; Naidoo 2007). Thus, more in-depth and interpretive insights regarding problems, fears and motivations associated with reproductive health and use and non-use of contraceptives need to be derived through the complementary inclusion of qualitative data. In this study, focus group discussions were deemed vital to fill gaps, which could not be addressed through quantitative data analysis.

The following categories of young women were represented in the groups: married and never married, with and without children, current users, non-users of contraceptives, school-goers and school dropouts. In total, six focus groups were held in both urban and rural areas. Each group consisted of 8 to 10 participants. Those in school were interviewed separately from the out-of-school young women and the groups were fairly homogeneous with regard to age. A semi-structured group interview format was adopted that ensured that the same subject matter was discussed in each group. However, apart from this guide, the group interviews offered space for the exploration of interesting issues that arose spontaneously. The discussions were audio recorded. Table 2 shows the age distribution of the young women who participated in the group discussions.

**Table 2: Age distribution of focus group participants**

| Age group    | no. of participants (N) | percent (%) |
|--------------|-------------------------|-------------|
| 15-16        | 8                       | 15          |
| 17-18        | 14                      | 26          |
| 19-20        | 9                       | 17          |
| 21-22        | 12                      | 23          |
| 23-24        | 10                      | 19          |
| <b>Total</b> | <b>53</b>               | <b>100</b>  |

(Source: Indongo, 2007)

Audiotapes were transcribed and focus group discussions that had been conducted in Oshiwambo were translated into English. The audio tapes of each focus group discussion were reviewed several times in order to get an adequate impression of the discussion climate and to construct verbatim transcriptions in which hesitations, silences, enthusiasm, anxiety and other socio-psychological indicators could be noted. The general findings, together with pertinent verbatim quotations, were then organised according to selected themes, so that different attitudes, beliefs and emotions could be illustrated and related to the quantitative data.

## Overview of General Results

### *Sample characteristics*

The majority of the 1776 sexually active women drawn out as the sample were between the ages of 20 and 24, and from the rural areas of Namibia. Most respondents had enrolled for or had obtained secondary or higher education and most (75 percent) were still unmarried at the time of the survey. Nevertheless, the majority of the young women reported having borne at least one child. Of interest is the fact that only 8 percent of the young women reported that they had discussed family planning issues with their mothers and only 10 percent discussed family planning with their partners.

**Table 3: Sexually active young women by background characteristics**

| <b>Characteristic</b>                  | <b>Percent (%)</b> | <b>Frequency (N)</b> |
|--|--------------------|----------------------|
| <b>Age group</b>                       |                    |                      |
| 15-19                                  | 39                 | 695                  |
| 20-24                                  | 61                 | 1081                 |
| <b>Place of residence</b>              |                    |                      |
| Urban                                  | 43                 | 761                  |
| Rural                                  | 57                 | 1015                 |
| <b>Discuss FP with partner</b>         |                    |                      |
| No                                     | 90                 | 1604                 |
| Yes                                    | 10                 | 170                  |
| <b>Discuss FP with mother</b>          |                    |                      |
| No                                     | 92                 | 1637                 |
| Yes                                    | 8                  | 137                  |
| <b>Regions</b>                         |                    |                      |
| Northwest                              | 28                 | 505                  |
| Northeast                              | 17                 | 305                  |
| Central                                | 27                 | 472                  |
| South                                  | 28                 | 494                  |
| <b>Time to nearest health facility</b> |                    |                      |
| Less than an hour                      | 77                 | 1373                 |
| 1 hour or more                         | 16                 | 291                  |
| <b>Education level</b>                 |                    |                      |
| None                                   | 8                  | 144                  |
| Primary                                | 26                 | 469                  |
| Secondary+                             | 66                 | 1163                 |
| <b>Marital status</b>                  |                    |                      |
| Not in union                           | 75                 | 1329                 |
| In union                               | 25                 | 447                  |
| <b>Number of living children</b>       |                    |                      |
| None                                   | 46                 | 824                  |
| At least 1                             | 54                 | 952                  |
| <b>Total</b>                           | <b>100</b>         | <b>1776</b>          |

(Source: NDHS, 2000)

**Findings: Determinants of contraceptive use**

Overall, the prevalence of contraceptive use among *sexually active young women* in Namibia stands at 52 percent. This prevalence is still below the Southern African region prevalence level of 60 percent (Asterline & Inding 2000; World Population Data Sheet 2006). Although the proportion of young women users has increased, there is still a large sector of sexually active young women who are not making use of contraception. The differences between users and non-users are explained in relation to characteristics presented in Table 4.

**Table 4: Age distribution of sexually active young women using contraceptive methods and their estimated odds ratios of the likelihood of contraceptive use, by background characteristics**

| <b>Characteristic</b>                       | <b>%</b> | <b>odds ratio</b> |
|---|----------|-------------------|
| <b>Educational level</b>                    |          |                   |
| Never been to school (r)                    | 35       | 1.000             |
| Primary education                           | 45       | 1.523             |
| Secondary or higher                         | 58       | 2.207**           |
| <b>Listen to radio at least once a week</b> |          |                   |
| No (r)                                      | 42       | 1.000             |
| Yes   | 54       | 1.289*            |
| <b>Read newspaper at least once a week</b>  |          |                   |
| No (r)                                      | 45       | 1.000             |
| Yes   | 58       | 1.449**           |
| <b>Health directorate</b>                   |          |                   |
| Northwest (r)                               | 44       | 1.000             |
| Northeast                                   | 52       | 1.208             |
| Central                                     | 64       | 1.769             |
| South                                       | 50       | 0.679**           |
| <b>Discuss FP with partner</b>              |          |                   |
| No (r)                                      | 51       | 1.000             |
| Yes   | 62       | 1.394             |
| <b>Discuss FP with mother</b>               |          |                   |
| No (r)                                      | 51       | 1.000             |
| Yes   | 65       | 1.108             |
| <b>Place of residence</b>                   |          |                   |
| Urban (r)                                   | 58       | 1.000             |
| Rural                                       | 48       | 0.608             |
| <b>Interactions</b>                         |          |                   |
| Not discuss FP with mother & urban (r)      | n/a      | 1.000             |
| Discuss FP with mother & rural              | n/a      | 1.690*            |
| Northwest & Urban (r)                       | n/a      | 1.000             |
| Northeast and rural                         | n/a      | 1.638             |
| Central & rural                             | n/a      | 1.319             |
| South & rural                               | n/a      | 3.006**           |

\*  $p < 0.05$ ; \*\*  $p < 0.01$ , based on Wald's chi-square test for the significance of the regression coefficient.

R = reference category; n/a = not significant,  $-2 \log \text{likelihood} = 2297.67^{**}$

(Source: NDHS, 2000)

The results show that contraceptive use is higher among young women with some level of education. Among those who have never been to school, only 35 percent reported that they use contraceptives. The logistic regression results show that young women with at least secondary education are more likely to use contraceptives than those who have never been to school (odds ratio = 2.207). This finding supports evidence from the international literature that displays a consistent argument about the regulating and empowering effects of completed secondary education, including increased



knowledge of fertility processes and positive attitudes towards use of modern contraception. As is the experience generally, increasing education would also affect the distribution of authority within Namibian households, enabling women to engage partners and parents on issues concerning sexual and intimate relations (Cochrane, 1979).

The data analysis reveals that media access also influences young women's use of contraceptive methods. Young women who reported that they listen to radio or read newspapers at least once a week use contraceptives more than those who do not have access to such media. For example, among young women who state that they listen to the radio at least once a week, 54 percent (odds ratio = 1.289) report that they use contraceptives. Similarly, for those who read newspapers or magazines the odds of using contraceptives equals 1.449. With regard to rural-urban differentiation, young women in the rural areas are less likely to use contraceptives than those in urban areas (odds ratio = 0.608). A total of 58 percent of young women who live in urban areas claim to use contraceptives as compared to 48 percent of young rural women. A further, and noteworthy, finding regarding urban or rural residence was on the question of how 'communication with mother on family planning issues' interacted with the young women's use of contraceptives. Whilst family planning discussions with mother was not significant as a main effect, it had a *significant interaction effect on contraceptive use* (See 'interactions' in Table 4). Young women in rural areas who discussed family planning with their mothers were more likely to use contraceptives than young women in urban areas who do not discuss family planning with their mothers (odds ratio = 1.690). *This is a strong indication of the importance of parental involvement (especially, the mother's intervention) in the reproductive health of young women.* Despite shifting intergenerational relations, Namibian parents are usually respected as knowledgeable, and thus are well placed to play a major role in nurturing the life skills and social practices of their children.

In formulating the research concerns of this project, the researchers surmised that young Namibian women who raise the topics of family planning or use of contraceptives with their mothers were likely to be discouraged or reprimanded for their pre-marital sexual activity, particularly in this era of increasing levels of HIV infection. Alternatively, if talking about family planning led to increased use of contraceptives, this could suggest a receptiveness, or a liberal pragmatism, on the part of mothers that could be harnessed in the interests of young women's health and that could consequently boost state initiatives to increase access to family planning. The data reviewed supported the latter, more progressive position. The results confirmed that as many as 65 percent of young women who discuss family planning issues with their mothers use contraceptives. In addition, the results also show a significant relationship between contraceptive use and discussing family planning with partner: 62 percent of those who discuss family planning with their partners use contraception. This is in line with the findings of Whitaker et al. (1999) who maintain that communicating with a partner is an important self-protective health measure that can aid one to learn about a partner's prior sexual behaviour and associated concerns that will inform safer sexual behaviours (see also Briggs 1998; Babalola 1999; Benefo 2004).

The results also show significant regional differentials in the use of contraceptives. Regional differentials are viewed in terms of interaction with place of residence (rural-urban). The results show that the odds of using contraceptives for young women who live in the rural areas in the South health directorate is three times the odds of young women using contraceptives who live in the urban areas of the Northwest health directorate. This indicates a generally low prevalence in contraceptive use among young women in the Northwest health directorate.

### Findings: Determinants of contraceptive method choice

Young women decide on what contraception to use on the basis of what is available and most convenient at the time (Agyei & Miggade 1995; Bugard 2004; Bender & Kosunen 2005). The results of the present study show a greater prevalence of modern contraceptive methods: the injection had the highest prevalence, followed by the male condom and then the pill.

**Table 5: Predicted probabilities for young women's choice of contraceptive methods, by selected variables**

| Variables                                   | Other methods | Pills | Condom | Injection |
|---|---------------|-------|--------|-----------|
| <b>Age (in years)</b>                       |               |       |        |           |
| 15-19                                       | 0.0095        | 0.132 | 0.304  | 0.554     |
| 20.24                                       | 0.0077        | 0.142 | 0.216  | 0.635     |
| <b>Discuss family planning with friends</b> |               |       |        |           |
| No  | 0.0142        | 0.138 | 0.232  | 0.616     |
| Yes   | 0.0022        | 0.141 | 0.288  | 0.569     |
| <b>Health Directorate</b>                   |               |       |        |           |
| North West                                  | 0.0047        | 0.089 | 0.682  | 0.224     |
| North East                                  | 0.0138        | 0.186 | 0.064  | 0.736     |
| Central                                     | 0.005         | 0.113 | 0.197  | 0.685     |
| South                                       | 0.0116        | 0.133 | 0.188  | 0.667     |
| <b>Number of living children</b>            |               |       |        |           |
| None  | 0.0059        | 0.097 | 0.507  | 0.394     |
| At least one                                | 0.0094        | 0.158 | 0.110  | 0.723     |
| <b>Marital status</b>                       |               |       |        |           |
| Not in union                                | 0.0077        | 0.120 | 0.241  | 0.631     |
| In union                                    | 0.0191        | 0.099 | 0.246  | 0.618     |
| <b>Education level</b>                      |               |       |        |           |
| Not been to school                          | 0.0037        | 0.111 | 0.237  | 0.648     |
| Primary                                     | 0.0105        | 0.211 | 0.261  | 0.517     |
| Secondary or higher                         | 0.0069        | 0.157 | 0.243  | 0.594     |
| <b>Time to nearest health facility</b>      |               |       |        |           |
| Less than 1 hour                            | 0.0089        | 0.125 | 0.260  | 0.606     |
| 1 hour or more                              | 0.0063        | 0.211 | 0.200  | 0.582     |

(Source: NDHS, 2000)

The results indicate that the youngest sector of sexually active users, i.e. those in the age group 15-19 years, have a higher prevalence of condom-use than those aged 20-24 years. Young women who discuss family planning with their friends also revealed a high percentage of those choosing to use condoms with partners. Condom-use was also higher among childless young women, while those with at least one living child chose the injection. The results also show a significant relationship between method choice and the marital status of a woman. Among married young women, the injection was the preferred choice, with the male condom, for the most part, unpopular. Some association was also noted between method choice and the educational level of young women. Only 14 percent of young women, who have never been to school, chose to use male condoms. Most of these women chose the injection. However, a higher percentage of young women with some level of education express a preference for male condoms.

Although the injection is the most preferred method, there are differentials in method choice with respect to health directorates. Young women who live in the Northwest health directorate had a higher probability (0.682) of choosing male condoms than any other contraceptive method. The Northwest health directorate comprises mainly the area that was formerly known as 'Ovamboland' where more than fifty percent of the Namibian population live. It is regarded as one of the most underdeveloped areas in Namibia, with poor health facilities and a high proportion of indigent people. It is also the area where traditional practices and staunch religion have currency in the rearing and socialisation of children. In the current context where the dangers of HIV infection are central in state and community health discourses, there are many programmes promoting the use of condoms countrywide. Through these programmes condoms are distributed and obtained freely at health centres, schools and other public places such as bars, restaurants and hotels. Hence, despite a social milieu in which women might actively seek out more secretive approaches to managing their fertility, for example, through injections, there seems to be sufficient room for the promotion of male condoms in Namibia. On the one hand, it might seem unusual for the condom to gain such wide acceptance in a rural-like environment but, on the other, it exists as testimony to the success of programmes that have been put in place in the country.

### **Qualitative Insights: Central themes of focus group discussions**

*Themes on contraceptive use: 'Constructive talk' and its effects on contraceptive use and health service utilisation*

The investigation of 53 young women's attitudes and opinions through guided group discussions was intended to throw additional light on the key findings of the quantitative data analysis. It was in these terms that family-based dialogues on matters of sex and pregnancy prevention were probed. Two general themes emerged in regard to parent-child communication. The first, relates to mutual insecurities (that is, of parents and young daughters). Poor parent-child communication was raised as a concern and as a barrier to young women's use of contraceptives. Some young women indicated that they did not feel comfortable speaking to parents; in many cases, parents were unaware that they were sexually active. Some young women indicated that they discussed contraceptive use mainly with their friends, who were an important source of

influence and information. For these women mothers were reticent and un-engaging. However, some young women suggested that in cases where mothers were more forthcoming, they did not 'feel free' to discuss sexual issues with their mothers. Thus, although there is room for meaningful discussions with their mothers this is debilitated by feelings of insecurity and norms of propriety guiding dialogue across the generational gap. The fear of negative sanctions was deeply embedded and most young women, especially from rural areas, talked about respecting adults and about feeling 'too guilty' to discuss sexual issues with them. Two vignettes are offered below:

My mother is never comfortable bringing up the discussion of sex with me. She has to first tell you a rumour about neighbours whose daughter fell pregnant before she drags you into what she wants to tell you (in school, aged 17, FG 3, 2004).

Discussing sexual issues with my father is totally out. My mother sometimes likes to bring up the topic when we are alone in the kitchen; but when she asks me anything about boyfriends or sex, I get very angry because I am embarrassed to talk to her about my sexual experiences (out of school, aged 22, FG 2, 2004).

Despite this, the second dominant theme on the topic of communication was the acknowledgement that mothers are wise and experienced and that younger women desire more talking and advice on the topics of sex, fertility and reproductive health. It was reiterated that most parents are willing to talk – but that they simply do not know how to bring up these topics for discussion. Mothers, as we learnt from the focus groups, were also less willing to talk about sex if their husbands were against it. Fathers of young girls were usually unhappy, believing that the conversations encouraged young women to contemplate early experimentation. In their view too much talking was part of the problem and not the solution to teenage pregnancy (see also Karim et al., 2003). The comments below illustrate the awkward space in which parent-child relations are being reworked in present-day Namibia:

Yes... parents really *have* to talk to us. If we have good platform and every parent in the community is supportive, we will not even be making mistakes of falling pregnant, we will not even contract STDs because we will be able to use contraceptives which are protective and safe every time. We will be able to have planned sexual intercourse because our boyfriends will be willing to wait until the right time rather than now when we have to involve ourselves in rush and take chances with sex (in school, 20, FG 5, 2004).

My mother is a good friend of mine. We talk a lot ... she gives me advice even regarding boyfriends and leaves the option for me to decide ... she warns me about the danger of falling pregnant when I am still young ..... and about HIV/AIDS ... However, I have a boyfriend in our neighbourhood and we have sexual intercourse ... my mother does not know about this ... I cannot talk to her about having sexual intercourse because I still do not know how she will react ... I rely on sneaking out of the house while she is at work during the day to have sex with my boyfriend ... Sex does not leave a scar on someone ... as you will still look the same after having it ... (in school, 17, urban, FG 5, 2004).

Now that I am at the University, my mother is more comfortable discussing contraception with me ... she knows I know a lot about contraceptives ... she is therefore sort of assured that I cannot fall pregnant because I can use contraceptives ... I think parents want us to use contraceptives but it is just *difficult* for them to tell us straight that we should use them (urban woman, 23, FG 5, 2004).

Apart from the familial context, a third theme emerging out of the focus group discussions was young women's expressed discomfort in negotiating contraceptive use in the public spaces of sexual and reproductive health facilities. Those who were married were more comfortable and felt freer to utilise health facilities than those who were unmarried. In addition, unmarried childless women viewed themselves as enduring immense prejudice and firm questioning from older health staff. One comment is referred to below:

The nurses at a nearby clinic are of the same age as my mother. I do not feel comfortable discussing my sexual problems with them. It is so embarrassing; they will think that I do not have respect for elders (out of school, rural, aged 23, FG 4, 2004).

After probing the 'type of nurses' the young women would find most preferable, there was general agreement that they wanted young nurses (of similar ages to themselves) to serve them. This is exemplified in the following statement:

If the nurse is of my age, and I know that she is not married, it's no problem I can talk to her freely because I know that she also has a boyfriend (in school aged 24, FG 3, 2004).

Access to health facilities was another factor that could impede health service utilisation and acquisition of contraceptives. The structural environmental factors like location of the clinic, time taken to be attended to, the physical and administrative structure, availability of youth-friendly personnel, privacy and, most importantly providers' attitudes and their manner of engagement were referred to as important factors that facilitate or hinder accessibility to health care. Provider attitudes and 'talking skills', similar to the case of dialogue with parents, were crucial in influencing young women's willingness to utilise available services. A young woman in one of the focus group discussions in the urban areas said the following:

I prefer the private clinic than the government owned hospital, because the way the nurses look at you and ask you questions, you will feel that you have committed the worst offence ever, but in the private hospital the nurses cannot really shout at you because it is business and they know that you are paying your money (out of school, 18, FG 6, 2004).

Others were concerned about the 'labelling' of the clinics that serve a specific clientele (the sexually active youth) as indicated in the following statement:

Some clinics have labels that are embarrassing like 'family planning'. Everyone who finds you there will know what you have come for (in school, 19, FG 5, 2004).

From the focus group exchanges it was clear that many young women would avoid such places for fear that their intimate affairs would become obvious to all. The vignettes referred to in this discussion highlight the fact that whilst state initiatives to create youth-friendly sexual and reproductive health services are to be welcomed, there should be constant monitoring of the social constraints that come into play and that could inhibit young women's accessing of such services.

### **Themes on contraceptive method choice: 'Gendered constraints' and their effect on selection of contraceptive methods**

In responding to questions on the contraceptives they are most familiar with, and which they might prefer, the women referred largely to modern methods such as the

condom, the injection and the pill. Whilst the quantitative data showed that the injection was most widely used, most of the women in the focus groups suggested that they preferred to use condoms. There were three reasons for this. First, a majority of the women talked about the condom as preferred because of its widespread availability, convenience, low cost and usefulness in preventing the spread of sexually transmitted infections as well as averting pregnancy. Below are some comments from the focus groups:

I think that the condom is the best method for young women because it is more discreet and used by the man. When you use the condom you are not only protected from unwanted pregnancy but also from STIs (urban 24, employed, FG 2, 2004).

Male condoms are easy to grab and can easily fit in a jeans pocket. Female condom is big and even if you want to grab, it cannot fit in a trousers pocket unless you have a handbag (college student, aged 21, FG 5, 2004).

I use the male condom because it is my boyfriend who carries it and he is the one who should suggest that we have to use it. He is a man and he has to take all sexual decisions. I cannot tell my boyfriend to use a condom unless he suggests it (out of school, aged 19, FG 2, 2004).

The fact that the female condom has to be inserted for some time before beginning sexual intercourse puts off the man's feelings. A man has to beg for sex for some time and a woman has to pretend even if she knows that she is ready for sex (university student, aged 23, FG 5, 2004).

A second reason for the popularity of condom-use has to do with suspicions of hormonal methods and beliefs that their use could lead to long-term sterility (Nare et al., 1997; Kaufman 1998; Maharaj 2006). This view persisted among young women regardless of their educational level. Here is one view:

I don't have any problem with the condom but regarding other methods of contraception, there can be side effects. For example, someone who uses pills to avoid unwanted pregnancy can find herself left sterile forever (out of school, 19, FG 4, 2004).

Schoolgirls, who expressed fears about the long-term consequences of the injectables, mentioned that time factors and clinic location were also barriers preventing them from going to clinics for injections. Clinics are located outside the school gates and girls would need permission from the principal or teachers to visit them during school hours. They also argued that clinics offered family planning services during weekdays only, leaving weekends for emergency cases only. Thus, condoms were a lot more convenient and easier to access (often on the school premises).

A minority of young women were not keen, and some of them quite resistant, to using condoms. Three reasons were offered for why this group of women found condoms problematic. First, condoms were regarded as working against the sustaining of a long-term and meaningful intimate union because they reduced sexual pleasure for both men and women. To some extent this seemed to be what women had heard from other people and was not derived entirely from their own lived or sexual experiences. Below are two statements that confirm this view:

If your boyfriend does not get sexual pleasure from you he will leave you for other girls who don't use condom. They will do it flesh-to-flesh and he will like it more than when you do it with condom (rural, aged 24, FG 4, 2004).

Sometimes when men use the condom they feel that they are not doing their duty as men in terms of sexual satisfaction; they like their women to feel fluid entering their bodies (rural, aged 19, FG 4, 2004).

A second problem concerned what the women described as the stigmatization that accompanies the possession and use of condoms. They reiterated that if a person was known to be using condoms, that person was regarded as promiscuous; hence users of condoms were regarded as having loose morals. The following statements support this:

If you are seen with a condom, even by your boyfriend or friends, you are stigmatized. You are seen as a 'cheap bitch' who is looking for men to sleep with (urban, aged 21, FG 6, 2004).

Condoms are good for us; the only problem is that you need to [negotiate] with your partner. If your partner does not understand it brings fighting around condom use again. Condoms involve participation of the men because he is the one to use it. Sometimes you are in a steady relationship that you don't want to spoil and [you then] leave everything to the man to decide (rural, aged 24, FG 2, 2004).

Religious teachings were cited, by some young women, as a third problem that acts to inhibit condom use. Some religions forbid the use of contraceptives, associating family planning with promiscuity and immorality. Most of the young women interviewed in this study belong to the Catholic and the Evangelical Lutheran churches. In Namibia, both of these churches are ardently opposed to premarital sexual relations. Although Catholics and the Evangelical Lutherans have organizations to fight STIs, including HIV/AIDS, their religions are still in support of abstinence for unmarried people and faithfulness to one partner for those in marriages. However, not all the women who belonged to these faiths subscribed fully to their practices. One woman claimed:

Christianity is not adhered to nowadays when it come to sexual practices; I go to church every Sunday but I still have sexual intercourse with my boyfriend either with or without a condom, although I am told every Sunday that sexual intercourse outside marriage is a sin and use of contraceptives is killing (urban, aged 24, FG 6, 2004).

In these circumstances, young women seemed to prefer the injectables to enable them to pursue their intimate relationships without inviting an unplanned pregnancy. Those who were out of school, especially, highlighted that the injection was the most convenient method for them for the reason indicated in the following statement:

When you are on injection, no one can tell that you are using any form of contraceptive, not even your boyfriend. [In addition] you do not need to remember anything everyday like taking the pill or carrying the condom. No one can even stigmatize you with sexual activities (urban, aged 23, FG 2, 2004).

The focus groups provided a safe setting for young women to express their thoughts and experiences of contraceptive use. It was striking that most of them talked so straightforwardly about their preference for the male condom. The injection was favoured largely in circumstances where the women desired discretion and did not believe that she had full control over her sexual and reproductive being. Some young women were afraid of being labelled unfavourably or stigmatised by family members or partners if condoms were to be found in their possession. Others preferred to use condoms but lacked the skills to engage partners or initiate conversations on the use of

condoms in their relationships. This raises questions about male dominance and young women's limited power to assert their preferences in intimate unions but also about a larger reticence embedded in the cultural and societal dynamics of personal and family relationships in Namibia. The young women emphasised that communication between sexual partners on how to prevent pregnancy or infection was often limited. As the macro-data in this article shows, where communication does indeed happen, the family planning and reproductive health benefits are considerable. Thus, in reflecting on their lives, the young women appropriately noted that initiatives were required to popularise talking about sexual issues, so that they could gain confidence in negotiating safer sexual practices and become more actively involved in decision-making on contraceptive use.

### **Concluding discussion**

The key determinant of young Namibian women's contraceptive use emerging out of this study was whether (or not) they communicated on matters of sex and reproduction with their mothers. The quantitative data analysis revealed that 'family planning discussions' with mother had a significant interaction effect on contraceptive use. Considering the staunch cultural and religious framework within which day-to-day activities are conducted, we speculated initially that talking routinely to mothers about family planning was likely to have a negative or discouraging influence on contraceptive use. The popular discourses, as exemplified by some of the focus group dialogues, suggest ambivalence on whether Namibian mothers would be pro- or anti-contraceptive use. Additionally, young women who have not been socialised to talk to their elders as equals may themselves resist any dialogue on topics dealing with intimacy. However, as was the case with Whitaker et al.'s (1999) study, communication with mothers (and parents generally) was talked about as desirable and necessary. In this sense, both the quantitative and qualitative data were quite consistent.

It was interesting to note that young women in rural areas who discuss family planning with their mothers were among those who had a very high probability of using contraceptives. The data analysis indicates, however, that only a small minority of young women discuss family planning in the private domain of the family, implying potentially significant possibilities that need to be further explored in future studies and interventions. These findings draw attention to the immense importance of educating parents, in particular mothers, about sexual and reproductive health issues and of the need to create the conditions for normalising talking about such issues. Parents need to be aware of the importance of reproductive health education if they are to play a vital role in alerting young women (who become sexually active) to the likelihood of pregnancy and infection. A more enlightened, contraceptive-conscious, younger generation would decrease the incidence of unwanted births in Namibia (Adetunji 2000; Population Report, 2003). In addition, de-stigmatising the condom (and the women who carry them) will serve vital and empowering contraceptive purposes. Meekers and Klein (2002) also conclude, in their study of young women in the Cameroon, that condom promotion programmes play an important role in reducing the incidences of unwanted pregnancies.



Parents' participation in guiding their children's sexual and reproductive behaviour is not stressed sufficiently in both Namibia's national reproductive health policy and the family planning policy. Instead, there is greater focus on cultivating better communication between intimate partners. Whilst the benefits associated with continuously engaging gender barriers and refashioning sexual unions to make them egalitarian are important (Agadjanian 2000; Richardson 1990) similar efforts have to be placed on raising awareness and sensitising parents, mature health workers and the 'elders' of the broader community to the particular needs of sexually active young women. As recommendations, we emphasise that policies and programmes should seek to creatively integrate several approaches in addressing the need for more substantive sexual and reproductive health education. This would be important in confronting the 'silences' that often leave young women in an information vacuum. Interventions should augment parental understandings and sensitivities as well as those of partners – understandings that could lead to improved abilities to prevent pregnancy as well as postponement of sexual initiation (Grunseit & Kippax 1993). Carefully constructed education programmes that work through parent's and young people's misconceptions and fears, would be more useful than the present state of denial and disengagement affecting intergenerational dialogue in many households. If *Parent Education Programmes* are organised in greater earnest they would go a long way towards breaking down socio-culturally constructed communication barriers and improving parents' skills in advising their children on sexual and reproductive health issues.

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