CHAPTER ONE

Introduction

1.1 Background to research problem

Contraception is defined as the practice of methods intended to prevent or space future pregnancy. Contraceptive use in this study will refer to whether or not a young woman reports using contraception. Contraceptive method choice in the context of this research will be referred to as the contraceptive method which a young woman[1] reports using at the time of the collection of data. Contraceptive methods can be divided into two categories: traditional and modern. Modern contraceptives are easily classifiable and include oral contraceptives, intrauterine devices (IUDs), female and male sterilisation, injections, condoms and the diaphragm. Other practices, which have a direct impact on fertility that have been used include prolonged breast feeding and postpartum sexual abstinence, which are probably used by mothers more for recuperating between births, child survival and child spacing rather than for limiting family size. Thus, these methods have not been considered as contraceptive methods although their fertility inhibiting characteristics are well recognised. Traditional methods recognised in this study include withdrawal, periodic abstinence, use of herbs and wearing of traditional beads.

Nearly 1.7 billion people, about one-third of the world's total population, are between the ages of 10 and 24 (Creel & Perry, 2003), with the vast majority living in developing countries. As they mature, young women (aged 15-24 years) are increasingly exposed to reproductive health risks such as sexually transmitted infections (STIs), unintended pregnancy and childbirth (United Nations (UN), 1998). The exposure to these risks has attracted considerable

[1] Young women refer to women aged 15-24 years.

research attention in different societies, in efforts both to understand its extent, causes and to address it as a problem. Studies in developed countries have shown a high incidence of such exposure (Mfono, 1998). Mfono (1998) further reports that Western European countries reacted with strong sex education programmes and adolescent contraceptive services, coupled with mandatory confidentiality. However, the United States lags behind other developed countries in the extent to which teenage fertility has declined (United Nations, 2003). Research in Latin America has also shown that a relatively high proportion of teenagers are exposed to the risk of pregnancy (World Health Organisation (WHO), 1989). Access to sex education and to family planning services is poor among adolescents in this region, and the incidence of teenage childbearing is high. Results from Asia vary, with early marriage and childbirth persisting in rural India despite the government prescribed minimum marriage age of 18 years for females (Singh, 1997). In China, abortions are increasing among teenagers, indicating rising sexual activity within this age-group (Ross et al., 1999). In Africa, studies (Muhwava, 1998; Burgard, 2004) have demonstrated that a large proportion of young women are exposed to the risk of conception, receive poor or no sex and contraceptive education, and experience a high incidence of adolescent childbirth.

The Namibian situation resembles that prevailing in developing societies in Africa and Latin America. Although reports indicate a decline in teenage pregnancy, most of the premarital births still occur among young women aged 15-24 years, the majority of whom are neither economically nor emotionally ready to deal with parental responsibilities. Thus, improving young women's reproductive health is key to improving the situation of women as well as the world's future generations (Creel & Perry, 2003). Young women's reproductive health needs are often overlooked or viewed through a lens of cultural values that limit care. The socio-cultural context in which young

women in Namibia find themselves has changed considerably within the past few generations. As in much of Africa, young women in Namibia are experiencing social turmoil resulting from conflicting values as the country becomes more urban and industrial. The smaller and slower paced communities of the past provided clear guidelines for young women in such aspects of their socialization as recreation, religion, relationship with elders and cultural rituals. In most ethnic groups like “Oshiwambo” group, “Kavango” group and “Caprivi” group, adolescence generally commenced with “Ohango yomeengoma”[2], a rite of passage that marked emergence from childhood to adulthood (Shapumba et al., 2004). They were allocated a tutor who explained their role in society to them and taught them about sexual behaviour and pregnancy. Such customs conferred peer-group identity and promoted a social and personal sense of belonging. Periodic abstinence, withdrawal and nonpenetrative sex were taught and widely practised as means of preventing pregnancy. Young women were taught about the “wrong time of the moon”, when a girl might get pregnant. Such traditions were by no means universal and some ethnic groups were highly restrictive of females. The “Oshiwambo”, “Kavango” and “Caprivi” groups for example, expected proof of female virginity at marriage, demonstrated by a certain amount of blood on the consummation bed, otherwise the bride would not be respected by in-laws. In addition, unmarried young women were also allowed to engage in a nonpenetrative form of sexual intercourse called “Okugwila”[3], which only happened when the two partners were known by both family elders (Mufune, 2003). However, with urbanisation and promotion of modern practices, most sexual socialization rituals are discarded. Educational functions, which formerly rested within the family and community, are increasingly being taken over by local and national governments, churches and community groups. These institutions must now unite diverse ethnic groups and develop a

[2] “ohango yomeengoma” refers to the Oshiwambo traditional wedding
[3] “okugwila” is to spend a night with a fiancée without having sexual intercourse

national message dealing with personal areas such as sexual activity. Conflict often results. Therefore, leaders remain apprehensive and uncomfortable about policies and legislation related to young women, such as those affecting sex education and access to contraceptives. The need for guidelines and programmatic intervention addressing these problems is clear. However, it requires an understanding of the many factors affecting young women's use of contraceptives, and very little analytical investigation of this subject has been done in Namibia.

Several researchers (Abdool et al. 1992; Agyei & Migadde, 1995; Khan & Rahman 1997; Karim et al. 2003) have indicated that sexually active young women need access to family planning information and services to prevent unwanted pregnancies. They also argued that young women need support and encouragement from their peers, adults and the media to use contraception effectively and consistently. However, improving contraceptive use by sexually active young women requires expanding and enhancing existing services as they often do not meet the demands of young women. Young women usually demand confidential, safe and convenient services (Hersh et al. 1998; Juarez 2002; Creel & Perry, 2003). They also demand that the social norms inhibiting young women's contraceptive use should be engaged with, that parents must openly discuss responsible and healthy sexual behaviour with them, that peers must be encouraged to teach each other about the importance of safe, protected sex and that the media must present positive images of healthy sexual behaviour (Brindis & Davis, 1998). At most health facilities in most sub-Saharan African countries, young women are not provided with advice and education on reproductive health matters (May et al. 1990; Marindo et al. 2003). This has contributed to young women's inability to effectively negotiate with either their partners or their parents on sexual and reproductive health issues.

During the past decade, in part as a result of the HIV/AIDS pandemic, young people and their health needs have been the subject of greater attention worldwide. Various international fora such as the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, the 1997 African Forum on Adolescent Reproductive Health held in Addis Ababa, Ethiopia, and the 1999 World Youth Forum held at the Hague, Netherlands, have addressed young peoples' sexual and reproductive health issues. At the Cairo Conference, all countries, including Namibia, which was a signatory, were advised to make accessible, through the primary health care system, reproductive health to all individuals of appropriate age (United Nations, 1994). Reproductive health care in the context of primary health care includes among others: family planning counselling, information, education, communication and services concerning reproductive and sexual health, including prevention of early pregnancies, sex education and the prevention of HIV, AIDS and other STDs. Access to and confidentiality and privacy of these services were also emphasized as well as parental guidance and support. At the Cairo Conference, one of the recommendations given to participating countries was to design reproductive health care programmes to serve the needs of young women in particular, and to involve young women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services.

In addition to the Cairo Conference, countries were requested to develop innovative programmes to make information, counselling and services for reproductive health accessible to young women and men. Furthermore, the Cairo Conference advised governments to promote greater community participation in reproductive health care services by decentralizing the management of public health programmes and by forming partnerships in cooperation with local non-governmental organizations and private health care providers (United Nations, 1994). Five years after the ICPD, the

importance of young peoples' health has been acknowledged, and numerous programmes have been developed to address their reproductive health needs (UNFPA, 1999[a]). For example in Namibia, there are currently campaigns and young people's programmes designed to provide information to young women on sexual and reproductive health. These include: media campaigns (radio and television services and advertisements) such as those developed by UNICEF, National Social Marketing for condoms (NASOMA) and the Ministry of Health and Social Services focusing on encouraging condom use among sexually active young people; the "My Future My Choice" campaign of UNICEF which provides sexual and reproductive health information, counselling and services through Multi-purpose youth centres; the "True Love Waits" campaign which is designed to help young people to develop self efficacy and decision making skills to protect themselves from unwanted pregnancies and sexually transmitted infections (STIs) including HIV/AIDS as well as other numerous programmes such as those run by the Catholic AIDS Action that promotes abstinence and monogamy and focuses on reaching young people in religious settings. However, much still needs to be done to ensure sustainability of these programmes and to make sure that initiatives from these programmes receive strong legislative support.

At the national level, many public and private institutions and organizations in sub-Saharan Africa have held numerous seminars, workshops and conferences not only to highlight the sexual and reproductive health issues of young people but also more importantly to devise programmes and strategies to prevent unwanted pregnancies (Tawiah, 2002). It is envisaged that arming young women with adequate knowledge of reproductive health matters will help pave the way to responsible parenthood and also enable them to make responsible decisions that affect their lives. Tawiah (2002) further reports that an estimated 64.1 per cent of the population under 25 years lives in sub-Saharan Africa. This suggests that a very high proportion of young people are

at, or are about, to reach reproductive age and are potential candidates for early parenthood. It is, therefore, quite obvious that neglecting the reproductive health needs of young people who form a significant proportion of the population in sub-Saharan Africa will have long-term adverse effects on the capabilities of our next generation, in particular the women.

A number of studies (Nelson et al. 2000; Ngalinda, 2001; Varga, 2003) have focused on young peoples' sexual behaviour in sub-Saharan Africa. Most of these studies report high levels of sexual activity among young women. They also indicate that young people's first sexual experiences take place in different social contexts from those of previous generations, where it was really important that "a woman is married as a virgin". Increased modernization and education, together with exposure to western media have been cited as having led to a decline in traditional values and, in particular, to have reduced the importance of maintaining virginity until marriage (Jackson & Harrison, 1999; Kinsman et al., 2000). Media programmes, especially in the form of entertainment, have the potential to provide health behaviour messages in a more palatable, culturally appropriate and interesting format than news (Masatu et al., 2003). For example, in Iran, a media campaign to increase contraceptive awareness and practice showed large increases in the number of both pill and condom users (Westoff & Rodriguez, 1995), while in Nigeria, mass media campaigns resulted in a large increase in the family planning clients at clinics.

Sexually active young women worldwide are at high risk of pregnancy, largely because they use ineffective methods or use contraception intermittently. Often those who use effective hormonal methods – the pill and the injectable – as well as condoms, have high discontinuation rates (Pachauri & Santhya, 2003). However, the implant, another hormonal method, which became available in the 1990s, has helped young women to use effective methods

successfully, contributing to recent declines in teenage pregnancy in the United States (Harper et al., 2004). Efforts to help sexually active young women to choose effective methods and to use them consistently are therefore essential to continued reductions in teenage pregnancy rates.

Because hormonal contraceptive methods are available only by prescription, using them requires a physician or clinic visit and thus the choice of these methods for young women resulted in low levels of use. Although a growing body of literature on the influence of parents, male partners and peers has informed understandings of young women's sexual risk behaviour and reproductive outcomes (Temin et al., 1999), information on the role that these key people play in young people's clinic visits for contraception is still limited. In general, parental support, involvement and communication can help young women to avoid sexual risk behaviour and pregnancy. Communication with parents on sexual topics typically occurs with the mother, although discussions about contraceptive method choices between young women and their mothers often occur only after a pregnancy. However, studies on parent-child communication on reproductive health issues, including contraception, did not attract the attention of researchers in the past and there are few comparable studies (Whitaker et al., 1999) on this subject. Most studies (Manlove et al., 2003; Magadi & Curtis, 2003; Chen & Guilkey, 2003) looked at partners' communication, which is of little significance for adolescents, and has more effect for young adults[4].

Peers on the other hand are an important influence on young women's sexual behaviour, although the association tends to be in the direction of increased, rather than reduced risk behaviour (Dilorio et al., 1999). Peer influence, as well as risk behaviour, may increase during middle adolescence (ages 15-16),

[4] Young adults refer to young women who are aged 20-24 years; adolescents would refer to those aged 15-19 years. Together, this group would constitute 'young women' (15-24 years).

whereas support from partners may be greater for older young women as they develop more stable relationships. Support from and communication with male partners can help to increase contraceptive use and decrease the likelihood of early pregnancy (Whitaker et al., 1999).

For programmes and service delivery of contraception to young women to be effective, it is important to understand how different factors work to support young women in their efforts to prevent unintended pregnancy. Data on young women's interaction with others when seeking contraception can help to improve contraceptive counselling, as well as inform policy debates on parental involvement in young women's clinic visits for contraception, male involvement in family planning, media campaigns and the use of peer programmes.

Substantial evidence is also found in existing literature that broadening the choice of contraceptive methods increases 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 suits their needs. Ross et al. (2001) confirm that prevalence of contraceptive use is highest in countries where access to a wide range of methods is uniformly high. Studies of contraceptive use and contraceptive methods choice among young women in countries in sub-Saharan Africa are few, probably because of the generally low contraceptive prevalence in the region. In addition, researchers have primarily focused on contraceptive use and method choice among married women, leaving the vulnerable unmarried young women unattended. A growing need, though, exists for an examination of contraceptive use and methods choice patterns among young women.

As mentioned earlier, several research studies (Bertrand et al., 2001; Magadi & Curtis, 2003; Rani & Lule, 2004) have looked at the individual and community influence on contraceptive use of young women but there is a dearth of knowledge in research on household influence, especially that of immediate family members on the use of contraceptives among young women. Although programmes that equip young women with sexual and reproductive health information exist in Namibia, parents and other community elders are left behind because there are very few programmes targeting them with regard to how they should communicate with their children on sexual issues.

1.2 Background information on Namibia

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. The central interior of the country is either arid or semi-arid grass or scrub savannas. Only to the north, towards the Angolan border, does mean annual rainfall increase and the land supports a semi-humid and sub-tropical climate.

Although Namibia's total population is only 1.8 million inhabitants, there is immense regional variation in population density. The bulk of the black rural population reside in the north along the perennial rivers which form the country's Northern border. About half the people make their living through agriculture, mainly from Karakul pelts, livestock, and dairy products (Central Statistics Office, 1996). Unemployment is high, and much of the land remains in the hands of several thousand white farmers; this has led to pressure for increased land redistribution, a process that began, albeit gradually, in mid-2004 (National Planning Commission, 2006). The country's few manufactured products are made up mostly of processed food. There is an extensive mining industry, run principally by foreign-owned companies. Namibia is a major

producer of gem-quality diamonds, the country's principal export. Other important minerals are uranium, copper, lead, gold, zinc, silver and tin. Fishing fleets operate in the Atlantic. Unrestricted fishing by commercial companies severely depleted the country's supply of certain types of fish, but stocks are being replenished. The central part of the country is served by roads and rail lines that are linked with those of South Africa, its largest trading partner (Central Statistics Office, 1996).

At the beginning of the century, the Germans colonised the country, setting up a basic 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 resulted in a highly inequitable income distribution. According to the Namibian income and expenditure survey report of 2006, the richest 5 per cent of the population control 71 per cent of the Gross Domestic Product (GDP). Approximately 47 per cent of the population is living in poverty, calculated in terms of household expenditure where more than 60 per cent of household income is spent on food (National Planning Commission, 2006). Namibia has an ethnically diverse population that includes the Bantu-speaking Ovambo, Kavango, and Herero; various Nama groups; the Damara; San (Bushmen); and whites of South African, German, and British descent. English is the official language, but most of the population speaks Afrikaans. About 80% of the population is Christian, and the rest follow traditional beliefs.

Namibia inherited a health structure that was segregated along racial lines and based entirely on curative health services. The administrative structure for delivery of health services was based on the Representative Authorities proclamation of 1980 which created a two-tier system, resulting in an unequal

allocation of resources and services. The ethnically based second tier was poorly funded and administrators could not raise the necessary income to provide basic health care services. As a result, there were large inequalities in the delivery of health care services in the country (Ministry of Health and Social Services, 1993[a]).

Namibia gained independence in March 1990. Shortly after independence, major changes occurred in all sectors, many of which have been restructured to meet the challenges facing the new nation in the post-apartheid era. The government of Namibia declared its commitment to the equitable distribution of resources and equity of access to basic services for those who are socially and economically disadvantaged (National Planning Commission, 1997). The health facilities in Namibia are currently divided into sub-divisions representing services offered, i.e. family planning, counselling, STD treatment service, antenatal care etc. Although this is regarded as an effective setup, young women do not usually consider this to be user-friendly because of the public marking displayed for each section.

Administratively, the country is divided into 13 regions, namely: the Caprivi, Kavango, Kunene, Omusati, Ohangwena, Oshana and Oshikoto regions in the north, the Omaheke, Otjozondjupa, Erongo and Khomas regions in the central areas and the Hardap and Karas in the south. However, the Ministry of Health and Social Services is operating through its four health directorates, namely: Northwest, constituting of Oshana, Oshikoto, Ohangwena and Omusati regions; Northeast, constituting of the Caprivi and Kavango regions; Central, constituting the Otjozondjupa, Erongo, Kunene regions and South, constituting of Omaheke, Khomas, Hardap and Karas regions.

The Namibian demographic and health survey (NDHS) conducted in 1992, two years after Namibia's independence, was the first ever nation-wide health

survey. It was taken at a stage when a large-scale re-organization of Namibia's health service was still ongoing and most primary health care programmes were only just being established, but showed significant impact. The results revealed that virtually all Namibian women aged between 15-49 years know at least one modern method of family planning and 41% of all women have used a contraceptive method at some stage in their lives. However, only 23% were using a contraceptive method at the time of the survey (Ministry of Health and Social Services, 1993[b]).

In 2000, ten years after independence, the Namibian government conducted a second Demographic and Health Survey. The survey provides a comprehensive source of information on a large number of health and demographic indicators at a point in time when the Ministry looks back on the first 10 years of a unified and comprehensive health service for the whole Namibia and its entire people. The survey results show that the contraceptive prevalence rate has increased from 23% of all women using contraceptive methods to 38% (Ministry of Health and Social Services, 2003). The overwhelming majority of current users employ modern contraceptive methods (more than 97%) while the use of traditional methods has fallen by more than half. Age at first marriage has increased since more women wait to complete their studies before they get married. Women in Namibia have been treated preferentially and empowered to occupy key positions in the government since the Beijing Conference in 1995. Education attainment and enrolment among women have also improved. In 2004, 94 percent of young women aged 15-24 years were literate and 65 percent were enrolled in secondary schools (PRB, 2005).

The last population census, which was conducted in 2001, on the other hand, revealed a total population of 1,826 854 with an annual growth rate of 2.6 per cent (Central Statistics Office, 2002). Adolescents and youth comprise about

40% of the population. The total sex ratio was 95 males per 100 females. Life expectancy for males and females was 44 and 41 respectively. Like many other developing countries, Namibia has a relatively young population due to the combination of moderately high birth rate (36 per thousand) and comparatively low death rate (20 per thousand).

According to the NDHS (2000), the average age at first intercourse is 18 years for young women. Unprotected sex puts young women at the risk of unwanted pregnancies, which may contribute to their dropping out of school, marrying early, abandoning babies and having unsafe abortions. Sexually active young women also face the risk of contracting HIV and other sexually transmitted infections. Namibia has one of the highest AIDS prevalence rates in the world (USAID, 2002). HIV infection rates are reported to be high among young people, and women are especially vulnerable. Most young women in Namibia are aware of HIV/AIDS and the risk of pregnancy but still engage in unprotected sex. According to the NDHS (2000) 53% of sexually active young women were using modern contraceptives, but only 16 % of them were using condoms.

The reproductive health and development of young people is now one of the priority areas for the Ministry of Health and Social Services (MOHSS, 2001[a]). The reproductive health programme in the MOHSS, which is also responsible for activities targeting young people, has developed a national reproductive health policy with a short component addressing adolescent and youth sexual reproductive health. In addition, the national school health policy under the Ministry of Education is addressing the overall health of school-going children and adolescents as well as the promotion of life skills, provision of health education on reproductive health and sexuality (National Planning Commission, 2000).

The national policy for reproductive health highlighted that early sexual experiences, pregnancy, HIV/AIDS and other sexually transmitted infections are some of the major factors giving rise to health problems among young people in Namibia (MOHSS, 2001[a]). The policy further states that shortage of skilled personnel, inadequate referral facilities, availability of integrated reproductive health care, difficult geographic access (in terms of the location of the health centre) and socio-cultural barriers to acceptance of reproductive health services, especially among men, are some of the constraints in addressing reproductive health. Facilities do not ensure adequate privacy and confidentiality due to lack of space, while interpersonal communication and interaction between service providers and clients are also poor (MOHSS, 2001[a]).

1.3 Statement of the problem

Young women often lack basic reproductive health information. They need information on the consequences of unprotected sexual intercourse and they also need to be well informed on developmental body changes. In addition to the above-mentioned information, young women need skills in negotiating sexual relationships, and knowledge about affordable confidential reproductive health services. Many do not feel comfortable discussing sexual issues with parents or other key adults with whom they can talk about their reproductive health concerns. Likewise, parents, health care workers, and educators frequently are unwilling or unable to provide complete, accurate, age-appropriate reproductive health information to young people. This is often due to their discomfort in discussing the subject or the false belief that providing the information will encourage increased sexual activity. Because of this, most young women enter into sexual relationships with very little knowledge on the consequences, either shared by their peers or from the media.

In response to the 1994 ICPD Programme of Action, the Namibian government introduced the reproductive health and family planning programme with the overall objective of promoting, protecting and improving the health of family members, especially women and children. The objective of the programme was to reduce maternal and infant deaths, increase contraceptive use among women of reproductive age, and promote and improve access to reproductive health services at all levels of health care delivery. The objectives of these programmes have not been fully achieved. There is need for continuous monitoring and evaluation of these programmes to make sure that they cater for the needs of all people who are targeted.

Furthermore, many activities have been undertaken to address the sexual and reproductive health problems of young women, without significant impact so far. The government of Namibia established the Ministry of Youth to coordinate and facilitate all youth activities through line ministries and non-governmental organizations (NGOs). Through this Ministry, multi-purpose youth resource centres were established in all 13 regions of the country with the purpose of serving as resource base for young people and to provide youth friendly services to address the needs of the youth. How accessible these centres are has been the subject of many questions over the past few years. Do they meet the needs of young women, and if not, why not? Do these facilities readily offer contraceptives to young women and do young women have choices when selecting contraceptives? These are some of the questions that frame the larger research problem.

The particular problem, which led to this study, has been the acknowledgement that teenage pregnancy and unwanted premarital childbirths have been on the increase in Namibia despite efforts on the part of the Ministry of Health and Social Services to provide adolescent friendly health and contraceptive services. Given the increasing vulnerability of young

women to the risk of unintended pregnancy, it is of program and policy relevance to better understand the barriers to effective contraceptive use among sexually active young women in order to help them lead health sexual and reproductive lives. This study is, therefore, of importance as it probes availability and accessibility of sexual and reproductive health services and informs policy makers on the gaps in the family planning policy, reproductive health policy and other policies that affect young women's reproductive health and contraceptive needs.

1.4 Purpose of the study

The study has three main objectives:

- To identify the demographic and behavioural determinants of contraceptive use among young women in Namibia.
- To examine the perceptions of young women with regard to the availability and accessibility of sexual and reproductive health services.
- To examine young women's use and choice of contraceptive methods.

These objectives will be achieved through an examination of the following research questions, hypotheses and assumptions:

- What determines contraceptive use among young women in Namibia?
- Why is contraceptive use still low among young women in Namibia? (In other words, are there cultural, traditional, behavioural, social, economic or demographic barriers in using contraceptives?)
- How do young women in Namibia make choices when considering the range of contraceptive methods?

In addition to the above research questions, the study will also consider the following assumptions and hypotheses listed as follows:

- There exist regional differentials in terms of how young women use sexual and reproductive health services and access them for contraceptives. Young women in the Northwest and Northeast health directorates are less likely to utilise sexual and reproductive services for contraceptives than young women in the Central and South health directorate.
- Young women who discuss family planning issues with their mothers are less likely to use contraceptive methods, because they are likely to be discouraged from engaging in sexual activities.
- Teenage women (15–19 years) are more likely to use condoms than young women aged 20-24 years.
- The negative experiences of young women who attempt to make use of sexual and reproductive health services for family planning purposes have a detrimental impact on their long-term utilisation of these services.

It should be emphasised that whilst these hypotheses are not novel, they require examination in the Namibian case. No other study to date has addressed and found substantive answers to the basic research questions raised about the situation of young women in Namibia.

1.5 Organisation of the thesis

Chapter one begins with the introduction to the research problem. Background information on Namibia is offered. The statement of the problem is highlighted and the purpose of the study is also outlined. Research questions are formulated and assumptions and hypotheses to be tested are presented. *Chapter two* discusses the theoretical and conceptual framework for analysing the use of contraceptive methods and for choice of method and reviews related literature. *Chapter three* discusses the sources of data and

methods of analysis. *Chapter four* presents the bivariate and multivariate results of determinants of contraceptive use and contraceptive method choice respectively. The *qualitative results* on issues related to contraceptive use and method choice are presented in chapter four. Finally, *chapter five* presents the summary of findings, conclusion and policy implications as well as recommendations.